INSURANCE CODE - INS

DIVISION 2. CLASSES OF INSURANCE [1880 - 12880.8] *(Division 2 enacted by Stats. 1935, Ch. 145.)*

PART 2. LIFE AND DISABILITY INSURANCE [10110 - 11549] *(Part 2 enacted by Stats. 1935, Ch. 145.)*

CHAPTER 1. The Contract [10110 - 10198.10] *(Chapter 1 enacted by Stats. 1935, Ch. 145.)*

ARTICLE 1. General Provisions [10110 - 10127.20] *(Article 1 enacted by Stats. 1935, Ch. 145.)*

10110. Every person has an insurable interest in the life and health of:

(a) Himself.

(b) Any person on whom he depends wholly or in part for education or support.

(c) Any person under a legal obligation to him for the payment of money or respecting property or services, of which death or illness might delay or prevent the performance.

(d) Any person upon whose life any estate or interest vested in him depends.

(Enacted by Stats. 1935, Ch. 145.)

10110.1. (a) An insurable interest, with reference to life and disability insurance, is an interest based upon a reasonable expectation of pecuniary advantage through the continued life, health, or bodily safety of another person and consequent loss by reason of that person's death or disability or a substantial interest engendered by love and affection in the case of individuals closely related by blood or law.

(b) An individual has an unlimited insurable interest in his or her own life, health, and bodily safety and may lawfully take out a policy of insurance on his or her own life, health, or bodily safety and have the policy made payable to whomsoever he or she pleases, regardless of whether the beneficiary designated has an insurable interest.

(c) Except as provided in Section 10110.4, an employer has an insurable interest, as referred to in subdivision (a), in the life or physical or mental ability of any of its directors, officers, or employees or the directors, officers, or employees of any of its subsidiaries or any other person whose death or physical or mental disability might cause financial loss to the employer; or, pursuant to any contractual arrangement with any shareholder concerning the reacquisition of shares owned by the shareholder at the time of his or her death or disability, on the life or physical or mental ability of that shareholder for the purpose of carrying out the contractual arrangement; or, pursuant to any contract obligating the employer as part of compensation arrangements or pursuant to a contract obligating the employer as guarantor or surety, on the life of the principal obligor. The trustee of an employer or trustee of a pension, welfare benefit plan, or trust established by an employer providing life, health, disability, retirement, or similar benefits to employees and retired employees of the employer or its affiliates and acting in a fiduciary capacity with respect to those employees, retired employees, or their dependents or beneficiaries has an insurable interest in the lives of employees and retired employees for whom those benefits are to be provided. The employer shall obtain the written consent of the individual being insured.

(d) Trusts and special purpose entities that are used to apply for and initiate the issuance of policies of insurance for investors, where one or more beneficiaries of those trusts or special purpose entities do not have an insurable interest in the life of the insured, violate the insurable interest laws and the prohibition against wagering on life.

(e) Any device, scheme, or artifice designed to give the appearance of an insurable interest where there is no legitimate insurable interest violates the insurable interest laws.

(f) An insurable interest shall be required to exist at the time the contract of life or disability insurance becomes effective, but need not exist at the time the loss occurs.

(g) Any contract of life or disability insurance procured or caused to be procured upon another individual is void unless the person applying for the insurance has an insurable interest in the individual insured at the time of the application.

(h) Notwithstanding subdivisions (a), (f), and (g), a charitable organization that meets the requirements of Section 214 or 23701d of the Revenue and Taxation Code may effectuate life or disability insurance on an insured who consents to the issuance of that

insurance.

(i) This section shall not be interpreted to define all instances in which an insurable interest exists.

(Amended by Stats. 2009, Ch. 343, Sec. 1. (SB 98) Effective January 1, 2010.)

10110.2. An insurer shall be entitled to rely upon all statements, declarations, and representations made by an applicant for insurance relative to the insurable interest that the applicant has in the insured, and no insurer shall incur any 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.

(Added by Stats. 1990, Ch. 1418, Sec. 2.)

10110.3. (a) An insurer may not issue an individual life insurance policy to an applicant that insures the life of the applicant's spouse unless the applicant's spouse has signed the policy application or has otherwise been notified in advance of the issuance of the policy.

(b) This section shall apply to policies of individual life insurance with face amounts exceeding fifty thousand dollars ($50,000) that are issued on or after July 1, 2004.

(Added by Stats. 2003, Ch. 115, Sec. 1. Effective January 1, 2004.)

10110.4. (a) Except as allowed in subdivision (c), an insurer may not issue or deliver a corporate-owned life insurance policy.

(b) "Corporate-owned life insurance policy" means a life insurance policy that is purchased by a California employer, that designates the employer as the beneficiary of the policy, and that insures the life of a California resident who is a current or former employee of the employer.

(c) This section does not apply to a policy insuring the life of a current or former exempt employee. An exempt employee is an administrative, executive, or professional employee who is exempt under Section 515 of the Labor Code and the regulations adopted pursuant thereto.

(d) Except as provided in subdivision (f), it is a violation of public policy for a California employer to purchase or hold a corporate-owned life insurance policy.

(e) (1) A corporate-owned life insurance policy purchased on or after the effective date of this section is void.

(2) Except as provided in subdivision (f), a corporate-owned life insurance policy purchased prior to the effective date of this section shall become void on the next premium payment date on or after the date five years from the effective date of this section, but no later than January 1, 2010.

(f) A corporate-owned life insurance policy purchased prior to the effective date of this section that insures the life of a current or former nonexempt employee shall continue in force after the effective date of this section provided that no further premium payments are made after the effective date of this section. However, an employer who has purchased and holds such a corporate-owned life insurance policy shall disclose in writing to the current or former nonexempt employee whose life is insured by the policy, within 90 days of the effective date of this section, all of the following information:

(1) The existence of the corporate-owned life insurance policy on the life of the nonexempt employee.

(2) The identity of the insurer under the policy.

(3) The benefit amount under the policy, unless the full amount of the benefit is used to defray the costs of nonexempt employee benefits.

(4) How benefits paid under the policy would be used.

(5) The name of the beneficiary under the policy.

(g) For a former employee, the disclosure requirements shall be deemed satisfied if the employer mails the required information to the former employee's last known address.

(Added by Stats. 2003, Ch. 328, Sec. 2. Effective January 1, 2004.)

10110.5. (a) A policy or endorsement issued by an admitted life and disability insurer may contain a provision for a waiver of premium payments in the event of involuntary unemployment of the insured. Insurers issuing policies or endorsements containing that provision shall establish any additional reserves and file any additional financial reports that the commissioner may require.

(b) A contract or supplemental contract issued by an admitted life and disability insurer may contain a provision for a waiver of surrender charge benefit for a life insurance or annuity contract in the event of voluntary or involuntary unemployment of the owner,

insured, or annuitant, as applicable. Insurers issuing contracts or supplemental contracts containing that provision shall establish any additional reserves and file any additional financial reports that the commissioner may require.

(Amended by Stats. 2013, Ch. 345, Sec. 1. (SB 281) Effective January 1, 2014.)

10110.6. (a) If a policy, contract, certificate, or agreement offered, issued, delivered, or renewed, whether or not in California, that provides or funds life insurance or disability insurance coverage for any California resident contains a provision that reserves discretionary authority to the insurer, or an agent of the insurer, to determine eligibility for benefits or coverage, to interpret the terms of the policy, contract, certificate, or agreement, or to provide standards of interpretation or review that are inconsistent with the laws of this state, that provision is void and unenforceable.

(b) For purposes of this section, "renewed" means continued in force on or after the policy's anniversary date.

(c) For purposes of this section, the term "discretionary authority" means a policy provision that has the effect of conferring discretion on an insurer or other claim administrator to determine entitlement to benefits or interpret policy language that, in turn, could lead to a deferential standard of review by any reviewing court.

(d) Nothing in this section prohibits an insurer from including a provision in a contract that informs an insured that as part of its routine operations the insurer applies the terms of its contracts for making decisions, including making determinations regarding eligibility, receipt of benefits and claims, or explaining policies, procedures, and processes, so long as the provision could not give rise to a deferential standard of review by any reviewing court.

(e) This section applies to both group and individual products.

(f) The commissioner may adopt regulations reasonably necessary to implement the provisions of this section.

(g) This section is self-executing. If a life insurance or disability insurance policy, contract, certificate, or agreement contains a provision rendered void and unenforceable by this section, the parties to the policy, contract, certificate, or agreement and the courts shall treat that provision as void and unenforceable.

(Added by Stats. 2011, Ch. 425, Sec. 1. (SB 621) Effective January 1, 2012.)

10110.7. (a) This section, except for subdivision (i), applies to a disability insurance policy that provides coverage for hospital, medical, or surgical benefits, excluding a specialized health insurance policy and a policy that provides excepted benefits as described in Sections 2722 (42 U.S.C. Sec. 300gg-21) and 2791 (42 U.S.C. Sec. 300gg-91) of the federal Public Health Service Act, subject to Section 10198.61.

(b) Notwithstanding any other law, a disability insurance policy shall cover the costs for COVID-19 diagnostic and screening testing and health care services related to the diagnostic and screening testing approved or granted emergency use authorization by the federal Food and Drug Administration for COVID-19, regardless of whether the services are provided by an in-network or out-of-network provider. Coverage required by this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing. Services related to COVID-19 diagnostic and screening testing include, but are not limited to, hospital or health care provider office visits for the purposes of receiving testing, products related to testing, the administration of testing, and items and services furnished to an insured as part of testing. Services related to COVID-19 diagnostic and screening testing do not include bonus payments for the use of specialized equipment or expedited processing.

(1) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the insurer shall reimburse the health care provider the amount of that lost cost sharing.

(2) A disability insurance policy shall not impose prior authorization or any other utilization management requirements on COVID-19 diagnostic and screening testing.

(3) With respect to an insured, a health insurer shall reimburse the provider of the testing according to either of the following:

(A) If the health insurer has a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(B) If the health insurer does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing with such provider, the insurer may negotiate a rate with such provider.

(4) (A) For an out-of-network provider with whom an insurer does not have a specifically negotiated rate for COVID-19 diagnostic and screening testing and health care services related to testing, an insurer shall reimburse the provider for all testing items or services in an amount that is reasonable, as determined in comparison to prevailing market rates for testing items or services in the geographic region where the item or service is rendered. An out-of-network provider shall accept this payment as payment in

full, shall not seek additional remuneration from an insured for services related to testing, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured.

(5) Beginning six months after the federal public health emergency expires, an insurer shall no longer be required to cover the cost sharing for COVID-19 diagnostic and screening testing and health care services related to testing when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this subdivision shall remain in effect after the federal public health emergency expires.

(c) (1) A disability insurance policy shall cover without cost sharing any item, service, or immunization that is intended to prevent or mitigate COVID-19 and that is either of the following with respect to the individual insured:

(A) An evidence-based item or service that has in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force.

(B) An immunization that has in effect a recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention regardless of whether the immunization is recommended for routine use.

(2) To the extent a health care provider would have been entitled to receive cost sharing but for this section, the insurer shall reimburse the health care provider the amount of that lost cost sharing.

(3) The item, service, or immunization covered pursuant to paragraph (1) shall be covered no later than 15 business days after the date on which the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention makes a recommendation relating to the item, service, or immunization. A recommendation from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention is considered in effect after it has been adopted, or granted emergency use authorization, by the Director of the Centers for Disease Control and Prevention.

(4) (A) A disability insurance policy subject to this subdivision shall not impose any cost-sharing requirements, including a copayment, coinsurance, or deductible, for any item, service, or immunization described in paragraph (1), regardless of whether such service is delivered by an in-network or out-of-network provider.

(B) A disability insurance policy shall not impose cost sharing for any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), including, but not limited to, provider office visits and vaccine administration, regardless of whether the service is delivered by an in-network or out-of-network provider.

(C) With respect to an insured, a health insurer shall reimburse the provider of the immunization according to either of the following:

(i) If the health insurer has a negotiated rate with such provider in effect before the public health emergency declared under Section 319 of the Public Health Service Act (42 U.S.C. Sec. 247d), such negotiated rate shall apply throughout the period of such declaration.

(ii) If the health insurer does not have a negotiated rate with such provider, the insurer may negotiate a rate with such provider.

(D) For an out-of-network provider with whom a disability insurer does not have a negotiated rate for an item, service, or immunization described in paragraph (1), an insurer shall reimburse the provider for all such items or services, including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1), in an amount that is reasonable, as determined in comparison to prevailing market rates for such items or services in the geographic region in which the item or service is rendered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an insured, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured for items, services, and immunizations described in paragraph (1), including any items or services that are necessary for the furnishing of an item, service, or immunization described in paragraph (1).

(E) Beginning six months after the federal public health emergency expires, an insurer shall no longer be required to cover the cost sharing for any item, service, or immunization described in paragraph (1) and to cover any items or services that are necessary for the furnishing of the items, services, or immunizations described in paragraph (1) when delivered by an out-of-network provider, except as otherwise required by law. All other requirements of this section shall remain in effect after the federal public health emergency expires.

(5) A disability insurer subject to this subdivision shall not impose prior authorization or any other utilization management requirements on any item, service, or immunization described in paragraph (1) or to items or services that are necessary for the furnishing of the items, services, or immunizations described in subparagraph (B) of paragraph (4).

(d) The commissioner may issue guidance to insurers regarding compliance with this section. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The department shall consult with the Department of Managed Health Care in issuing the guidance specified in this subdivision.

(e) This section, excluding subdivision (i), shall apply retroactively beginning from the Governor's declared State of Emergency related to the SARS-CoV-2 (COVID-19) pandemic on March 4, 2020.

(f) For purposes of this section:

(1) "Diagnostic testing" means all of the following:

(A) Testing intended to identify current or past infection and performed when a person has signs or symptoms consistent with COVID-19, or when a person is asymptomatic but has recent known or suspected exposure to SARS-CoV-2.

(B) Testing a person with symptoms consistent with COVID-19.

(C) Testing a person as a result of contact tracing efforts.

(D) Testing a person who indicates that they were exposed to someone with a confirmed or suspected case of COVID-19.

(E) Testing a person after an individualized clinical assessment by a licensed health care provider.

(2) "Screening testing" means tests that are intended to identify people with COVID-19 who are asymptomatic and do not have known, suspected, or reported exposure to SARS-CoV-2. Screening testing helps to identify unknown cases so that measures can be taken to prevent further transmission. Screening testing includes all of the following:

(A) Workers in a workplace setting.

(B) Students, faculty, and staff in a school setting.

(C) A person before or after travel.

(D) At home for someone who does not have symptoms associated with COVID-19 and does not have a known exposure to someone with COVID-19.

(g) This section does not relieve an insurer from continuing to cover testing as required by federal law and guidance.

(h) The department shall hold insurers accountable for timely access to services required under this section and coverage requirements established under federal law, regulations, or guidelines.

(i) (1) This subdivision applies to a disability insurance policy issued, amended, or renewed on or after the operative date of this subdivision that covers hospital, medical, surgical, or prescription drug benefits, excluding a specialized health insurance policy that provides coverage only for dental or vision benefits, with respect to therapeutics for COVID-19 covered under the policy, which shall include therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for treatment of COVID-19 when prescribed or furnished by a licensed health care provider acting within their scope of practice and the standard of care.

(2) A disability insurer shall reimburse a provider for the therapeutics described in paragraph (1) at the specifically negotiated rate for those therapeutics, if the insurer and provider have negotiated a rate. If the insurer does not have a negotiated rate with a provider, the insurer may negotiate a rate with the provider.

(3) For an out-of-network provider with whom a disability insurer does not have a negotiated rate for the therapeutics described in paragraph (1), a disability insurer shall reimburse the provider for the therapeutics in an amount that is reasonable, as determined in comparison to prevailing market rates for the therapeutics in the geographic region in which the therapeutic was delivered. An out-of-network provider shall accept this payment as payment in full, shall not seek additional remuneration from an insured, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured for therapeutics described in this subdivision.

(4) A disability insurer shall cover COVID-19 therapeutics without cost sharing, regardless of whether the therapeutics are provided by an in-network or out-of-network provider, and without utilization management. If a provider would have been entitled to receive cost sharing but for this section, the disability insurer shall reimburse the provider for the amount of that lost cost sharing. A provider shall accept this payment as payment in full, shall not seek additional remuneration from an insured, and shall not report adverse information to a consumer credit reporting agency or commence civil action against the insured for therapeutics pursuant to this subdivision.

(5) Beginning six months after the federal public health emergency expires, a disability insurer shall no longer be required to cover the cost sharing for COVID-19 therapeutics delivered by an out-of-network provider, unless otherwise required by law. All other

requirements of this subdivision shall remain in effect after the federal public health emergency expires.

(Amended by Stats. 2022, Ch. 545, Sec. 4. (SB 1473) Effective September 25, 2022.)

10110.75. (a) This section applies to a disability insurance policy that provides coverage for hospital, medical, surgical, or prescription drug benefits, excluding a specialized health insurance policy that provides coverage only for dental or vision benefits.

(b) (1) A disability insurance policy shall cover, without cost sharing and without prior authorization or other utilization management requirements, the costs of the following health care services to prevent or mitigate a disease when the Governor of the State of California has declared a public health emergency due to that disease:

(A) An evidence-based item, service, or immunization that is intended to prevent or mitigate a disease as recommended by the United States Preventive Services Task Force that has in effect a rating of “A” or “B” or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention.

(B) A health care service or product related to diagnostic and screening testing for the disease that is approved or granted emergency use authorization by the federal Food and Drug Administration, or is recommended by the State Department of Public Health or the federal Centers for Disease Control and Prevention.

(C) Therapeutics approved or granted emergency use authorization by the federal Food and Drug Administration for the disease.

(2) The item, service, or immunization covered pursuant to subparagraph (A) of paragraph (1) shall be covered no later than 15 business days after the date on which the United States Preventive Services Task Force or the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention makes a recommendation relating to the item, service, or immunization.

(Amended by Stats. 2022, Ch. 545, Sec. 5. (SB 1473) Effective September 25, 2022.)

10110.8. (a) A life or disability insurance policy other than health insurance, as defined in Section 106, issued, amended, renewed, or delivered on or after January 1, 2020, shall not do any of the following based solely and without any additional actuarial risks upon the status of a person as a living organ donor:

(1) Refuse to insure, or refuse to continue to insure, the person under a life or disability insurance policy.

(2) Limit the amount, extent, or kind of coverage available to the person under a life or disability insurance policy.

(3) Charge the person a different rate for the same coverage under a life or disability insurance policy.

(4) Otherwise discriminate in the offering, issuance, cancellation, amount of coverage, price, or any other condition of a life or disability insurance policy for the person.

(b) With respect to any health condition other than being a living organ donor, a person who is a living organ donor shall be subject to the same standards of sound actuarial principles or actual or reasonably anticipated experience as persons who are not living organ donors.

(c) For purposes of this section, “living organ donor” means an individual who has donated all or part of an organ and is not deceased.

(Added by Stats. 2019, Ch. 316, Sec. 4. (AB 1223) Effective January 1, 2020.)

10111. In life or disability insurance, the only measure of liability and damage is the sum or sums payable in the manner and at the times as provided in the policy to the person entitled thereto.

(Amended by Stats. 1935, Ch. 246.)

10111.2. (a) Under a policy of disability insurance other than health insurance, as defined in Section 106, including a policy of disability income insurance, as defined in subdivision (c) of Section 799.01, payment of benefits to the insured shall be made within 30 calendar days after the insurer has received all information needed to determine liability for a claim. However, the 30-calendar-day period shall not include any time during which the insurer is doing any of the following:

(1) Awaiting a response for relevant medical information from a health care provider.

(2) Awaiting a response from the claimant to a request for additional relevant information.

(3) Investigating possible fraud that has been reported to the department's Fraud Division in compliance with subdivision (a) of Section 1872.4.

(b) If the insurer has not received all information needed to determine liability for a claim within 30 calendar days after receipt of the claim, the insurer shall notify the insured in writing and include a written list of all information it reasonably needs to determine liability for the claim. In that event, the 30-calendar-day period set out in subdivision (a) shall commence when the insured has provided to the insurer all information in that notification. If no notice is sent by the insurer within 30 calendar days after the claim is filed by the insured, interest shall begin to accrue on the payment of benefits on the 31st calendar day after receipt of the claim, at the rate of 10 percent per year.

(c) When the insurer has received all information needed to determine liability for a claim, and the insurer determines that liability exists and fails to make payment of benefits to the insured within 30 calendar days after the insurer has received that information, any delayed payment shall bear interest, beginning the 31st calendar day, at the rate of 10 percent per year. Liability shall, in all cases, be determined by the insurer within 30 calendar days of receiving all information set out in the insurer's written notification to the insured.

(d) Nothing in this section is intended to restrict any other remedies available to an insured by statute or any other law.

(Amended by Stats. 2022, Ch. 424, Sec. 25. (SB 1242) Effective January 1, 2023.)

10111.5. An insurer shall not be liable for payments claimed under an individual or group policy of life insurance if the duty to make those payments depends upon a factual determination of whether the death of the insured was an accident or a suicide and that fact cannot be established without an autopsy and the autopsy is prohibited under Section 27491.43 of the Government Code. Insurers refusing or delaying payments in those circumstances in good faith shall not be liable for exemplary or punitive damages.

(Added by Stats. 1984, Ch. 1731, Sec. 2.)

10111.7. (a) An insurer shall not deny or refuse to accept an application for life insurance, or refuse to insure, refuse to renew, cancel, restrict, or otherwise terminate a policy of life insurance, or charge a different rate for the same life insurance coverage, based solely upon the applicant's or insured's past or future lawful travel destinations.

(b) Nothing in this section shall prohibit an insurer from excluding or limiting coverage under a life insurance policy, or refusing to offer life insurance, based upon lawful travel, or from charging a different rate for that coverage, when that action is based upon sound actuarial principles or is related to actual and reasonably expected experience.

(Added by Stats. 2005, Ch. 446, Sec. 1. Effective January 1, 2006.)

10112. Subject to Section 2459 of the Probate Code, in respect to life or disability insurance, or annuity contracts (except as provided in Sections 2500 to 2507, inclusive, of the Probate Code and Section 3500 of the Probate Code and Chapter 4 (commencing with Section 3600) of Part 8 of Division 4 of the Probate Code), heretofore or hereafter issued to or upon the life of any person not of a full 18 years of age for the benefit of such minor or for the benefit of the father, mother, spouse, child, brother, or sister, of such minor, or issued to such minor, subject to written consent of a parent or guardian, upon the life of any person in whom such minor has an insurable interest for the benefit of himself or herself or such minor's father, mother, spouse, child, brother or sister, such minor shall not, by reason only of such minority, be deemed incompetent to contract for such insurance or annuity, or for the surrender thereof, or to exercise all contractual rights thereunder, or, subject to approval of a parent or guardian, to give a valid discharge for any benefit accruing or for any money payable thereunder; provided, that all such contracts made by a minor under 16 years of age, as determined by the nearest birthday, shall have the written consent of a parent or guardian, and that the exercise of all contractual rights under such contracts, or the surrender thereof, or the giving of a valid discharge for any benefit accruing or money payable thereunder, in the case of a minor under 16 years of age, as determined by the nearest birthday, shall have the written consent of a parent or guardian.

All such contracts made by a minor not of a full 18 years of age which may result in any personal liability for assessment shall have the written assumption of any such liability by a parent or guardian in consideration of the issuance of the contract. Such assumption shall be in a form approved by the commissioner, reasonably designed to inform the parent or guardian of the liability thus assumed.

Such assumption of liability may be made a part of and included with any written consent of such parent or guardian required under other provisions of this section and it may be provided therein that such assumption shall cover only up to the anniversary date of the policy nearest to the member's birthday at which he or she attains 18 years of age.

(Amended by Stats. 2016, Ch. 50, Sec. 57. (SB 1005) Effective January 1, 2017.)

10112.1. (a) An individual or group health insurance policy shall not establish either of the following:

(1) Lifetime limits on the dollar value of any covered benefits for an insured, whether provided in network or out of network.

(2) Annual limits on the dollar value of any covered benefits for an insured, whether provided in network or out of network.

(b) Subdivision (a) does not prevent a group health insurance policy from placing annual or lifetime per-insured limits on specific covered benefits that are not essential health benefits, as defined under Section 10112.27, to the extent that those limits are otherwise permitted under state law.

(c) This section does not apply to a specialized health insurance policy that does not cover an essential health benefit, as defined under Section 10112.27, or a Medicare supplement policy.

(Repealed and added by Stats. 2020, Ch. 302, Sec. 15. (SB 406) Effective September 29, 2020.)

10112.2. (a) A group or individual nongrandfathered health insurance policy shall, at a minimum, provide coverage for and shall not impose any cost-sharing requirements for any of the following:

(1) Evidence-based items or services that have in effect a rating of “A” or “B” in the recommendations of the United States Preventive Services Task Force, as periodically updated.

(2) Immunizations that have in effect a recommendation, as periodically updated, from the Advisory Committee on Immunization Practices of the federal Centers for Disease Control and Prevention with respect to the individual involved.

(3) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided in the comprehensive guidelines, as periodically updated, supported by the United States Health Resources and Services Administration.

(4) With respect to women, those additional preventive care and screenings not described in paragraph (1) as provided for in comprehensive guidelines supported by the United States Health Resources and Services Administration for purposes of this paragraph.

(5) For the purposes of this section:

(A) The current recommendations of the United States Preventive Services Task Force regarding breast cancer screening, mammography, and prevention shall be considered the most current other than those issued in or around November 2009.

(B) A health insurance policy issued, amended, or renewed on or after January 1, 2025, shall not impose any cost-sharing requirements for any items or services that are integral to the provision of an item or service that is required by this section, regardless of whether or not the integral item or service is billed separately from an item or service that is required by this section.

(6) A health insurance policy shall not impose cost sharing for office visits associated with the preventive care services described in this section if the preventive care service is not billed separately, or is not tracked as an individual encounter separately, from the office visit and the primary purpose of the office visit is the delivery of the preventive care service.

(b) This section does not prohibit a health insurance policy from doing either of the following:

(1) Providing coverage for preventive items or services in addition to those required by subdivision (a).

(2) Denying coverage for services that are not recommended by the United States Preventive Services Task Force, except as provided in subdivision (d).

(c) A health insurer shall provide coverage pursuant to subdivision (a) for policy years that begin on or after the date that is one year after the date the recommendation or guideline is issued.

(1) A health insurer that is required to provide coverage for any items and services specified in a recommendation or guideline described in subdivision (a) on the first day of a policy year shall provide coverage through the last day of the policy year, even if the recommendation or guideline changes or is no longer described in subdivision (a) during the policy year.

(2) Notwithstanding paragraph (1), if a recommendation or guideline described in paragraph (1) of subdivision (a) that was in effect on the first day of a policy year is downgraded to a “D” rating, or if any item or service associated with any recommendation or guideline specified in subdivision (a) is subject to a safety recall or is otherwise determined to pose a significant safety concern by a federal agency authorized to regulate the item or service during a policy year, a health insurer is not required to cover the item or service through the last day of the policy year.

(d) A health insurance policy issued, amended, or renewed on or after January 1, 2025, shall cover items and services pursuant to this section in accordance with any applicable requirement of this part, including, but not limited to, Section 10123.18 on cervical

cancer screening, Section 10123.1933 on prophylaxis of HIV infection, Section 10123.207 on colorectal cancer screening, and Section 10123.208 on home test kits for sexually transmitted diseases.

(e) This section does not apply to a specialized health insurance policy that does not cover an essential health benefit, as defined in Section 10112.27. This section shall only apply to a health savings account-eligible health insurance policy to the extent it does not fail to be treated as a high deductible health insurance policy under Section 223 of Title 26 of the United States Code.

(f) The department shall coordinate with the Department of Managed Health Care if it adopts regulations to implement this section.

(g) The commissioner may exercise the authority provided by this code and the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340), Chapter 4.5 (commencing with Section 11400), and Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code) to implement and enforce this section and all sections related to preventive services, including those referenced herein. If the commissioner assesses a civil penalty for a violation, any hearing that is requested by the insurer may be conducted by an administrative law judge of the Administrative Hearing Bureau of the department under the formal procedure of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code. A civil penalty shall not exceed five thousand dollars ($5,000) for each violation, or, if a violation was willful, shall not exceed ten thousand dollars ($10,000) for each violation. This subdivision does not impair or restrict the commissioner's authority pursuant to another provision of this code or the Administrative Procedure Act.

(Amended by Stats. 2024, Ch. 708, Sec. 2. (AB 2258) Effective January 1, 2025.)

10112.25. (a) A health insurer that issues, sells, renews, or offers health insurance policies for health care coverage in this state, including a grandfathered health plan, but not including specialized health insurance policies that provide only dental or vision services, shall provide an annual rebate to each insured under that coverage, on a pro rata basis, if the ratio of the amount of premium revenue expended by the health insurer on the costs for reimbursement for clinical services provided to insureds under that coverage and for activities that improve health care quality to the total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance, is less than the following:

(1) With respect to a health insurer offering coverage in the large group market, 85 percent.

(2) With respect to a health insurer offering coverage in the small group market or in the individual market, 80 percent.

(b) A health insurer that issues, sells, renews, or offers health insurance policies for health care coverage in this state, including a grandfathered health plan, shall comply with the following minimum medical loss ratios:

(1) With respect to a health insurer offering coverage in the large group market, 85 percent.

(2) With respect to a health insurer offering coverage in the small group market or in the individual market, 80 percent.

(c) (1) The total amount of an annual rebate required under this section shall be calculated in an amount equal to the product of the following:

(A) The amount by which the percentage described in paragraph (1) or (2) of subdivision (a) exceeds the ratio described in paragraph (1) or (2) of subdivision (a).

(B) The total amount of premium revenue, excluding federal and state taxes and licensing or regulatory fees and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance.

(2) A health insurer shall provide a rebate owing to an insured no later than September 30 of the calendar year following the year for which the ratio described in subdivision (a) was calculated.

(d) The commissioner may adopt regulations in accordance with the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) that are necessary to implement the medical loss ratio as described under Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18), and any federal rules or regulations issued under that section.

(e) The requirements of this section shall be implemented as described in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91) and the requirements of Section 2718 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and any rules or regulations issued under those sections as in effect on January 1, 2017.

(f) This section does not apply to a health care service plan contract or insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code).

(Amended by Stats. 2018, Ch. 678, Sec. 2. (AB 2499) Effective January 1, 2019.)

10112.26. (a) A health insurer that issues, sells, renews, or offers a policy covering dental services shall file a report with the department, by July 31 of each year, which shall be known as the MLR annual report. The MLR annual report shall be organized by market and product type and contains the same information required in the 2013 federal Medical Loss Ratio (MLR) Annual Reporting Form (CMS-10418). The department shall post a health insurer's MLR annual report on its Internet Web site within 45 days after receiving the report.

(b) The MLR reporting year shall be for the calendar year during which dental coverage is provided by the plan. As applicable, all terms used in the MLR annual report shall have the same meaning as used in the federal Public Health Service Act (42 U.S.C. Sec. 300gg-18) and Part 158 (commencing with Section 158.101) of Title 45 of the Code of Federal Regulations.

(c) If the commissioner decides to conduct an examination, as described in Section 730, because the commissioner finds it necessary to verify the health insurer's representations in the MLR annual report, the department shall provide the health insurer with a notification 30 days before the commencement of the examination.

(d) The health insurer shall have 30 days from the date of notification to electronically submit to the department all requested records, books, and papers specified in subdivision (a) of Section 733. The commissioner may extend the time for a health insurer to comply with this subdivision upon a finding of good cause.

(e) The department shall make available to the public all of the data provided to the department pursuant to this section.

(f) This section does not apply to an insurance policy issued, sold, renewed, or offered for health care services or coverage provided in the Medi-Cal program (Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code), the Medi-Cal Access Program (Chapter 2 (commencing with Section 15810) of Part 3.3 of Division 9 of the Welfare and Institutions Code), or the California Major Risk Medical Insurance Program (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code), to the extent consistent with the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(g) This section does not apply to disability insurance for covered benefits in the single specialized area of dental-only health care that pays benefits on a fixed benefit, cash payment only basis.

(h) The department may issue guidance to health insurers of specialized health insurance policies subject to this section regarding compliance with this section. The guidance shall not be subject to the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code), and shall be effective only until the department adopts regulations pursuant to that act. The department shall consult with the Department of Managed Health Care in issuing the guidance specified in this section.

(Amended by Stats. 2018, Ch. 933, Sec. 4. (SB 1008) Effective January 1, 2019.)

10112.27. (a) An individual or small group health insurance policy issued, amended, or renewed on or after January 1, 2017, shall include, at a minimum, coverage for essential health benefits pursuant to the federal Patient Protection and Affordable Care Act (PPACA) and as outlined in this section. This section shall exclusively govern the benefits a health insurer must cover as essential health benefits. For purposes of this section, "essential health benefits" means all of the following:

(1) Health benefits within the categories identified in Section 1302(b) of PPACA: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services, including oral and vision care.

(2) (A) The health benefits covered by the Kaiser Foundation Health Plan Small Group HMO 30 plan (federal health product identification number 40513CA035) as this plan was offered during the first quarter of 2014, as follows, regardless of whether the benefits are specifically referenced in the plan contract or evidence of coverage for that plan:

(i) Medically necessary basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code and Section 1300.67 of Title 28 of the California Code of Regulations.

(ii) The health benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in the following sections of the Health and Safety Code: Sections 1367.002, 1367.06, and 1367.35 (preventive services for children); Section 1367.25 (prescription drug coverage for contraceptives); Section 1367.45 (AIDS vaccine); Section 1367.46 (HIV testing); Section 1367.51 (diabetes); Section 1367.54 (alpha-fetoprotein testing); Section 1367.6 (breast cancer screening); Section 1367.61 (prosthetics for laryngectomy); Section 1367.62 (maternity hospital stay); Section 1367.63 (reconstructive surgery); Section 1367.635 (mastectomies); Section 1367.64 (prostate cancer); Section 1367.65 (mammography); Section 1367.66 (cervical cancer); Section 1367.665 (cancer screening tests); Section 1367.67 (osteoporosis); Section 1367.68 (surgical procedures for jaw bones); Section 1367.71 (anesthesia for dental); Section 1367.9 (conditions attributable to diethylstilbestrol); Section 1368.2 (hospice care); Section 1370.6 (cancer clinical trials);

Section 1371.5 (emergency response ambulance or ambulance transport services); subdivision (b) of Section 1373 (sterilization operations or procedures); Section 1373.4 (inpatient hospital and ambulatory maternity); Section 1374.56 (phenylketonuria); Section 1374.17 (organ transplants for HIV); Section 1374.72 (mental health parity); and Section 1374.73 (autism/behavioral health treatment).

(iii) Any other benefits mandated to be covered by the plan pursuant to statutes enacted before December 31, 2011, as described in those statutes.

(iv) The health benefits covered by the plan that are not otherwise required to be covered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, to the extent otherwise required pursuant to Sections 1367.18, 1367.21, 1367.215, 1367.22, 1367.24, and 1367.25 of the Health and Safety Code, and Section 1300.67.24 of Title 28 of the California Code of Regulations.

(v) Any other health benefits covered by the plan that are not otherwise required to be covered under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(B) If there are any conflicts or omissions in the plan identified in subparagraph (A) as compared with the requirements for health benefits under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code that were enacted before December 31, 2011, the requirements of Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code shall control, except as otherwise specified in this section.

(C) Notwithstanding subparagraph (B) or any other provision of this section, the home health services benefits covered under the plan identified in subparagraph (A) shall not be in conflict with Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code.

(D) For purposes of this section, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343) shall apply to a policy subject to this section. Coverage of mental health and substance use disorder services pursuant to this paragraph, along with any scope and duration limits imposed on the benefits, shall be in compliance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Public Law 110-343), and all rules, regulations, and guidance issued pursuant to Section 2726 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-26).

(3) With respect to habilitative services, in addition to any habilitative services and devices identified in paragraph (2), coverage shall also be provided as required by federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA. Habilitative services and devices shall be covered under the same terms and conditions applied to rehabilitative services and devices under the policy. Limits on habilitative and rehabilitative services and devices shall not be combined.

(4) With respect to pediatric vision care, the same health benefits for pediatric vision care covered under the Federal Employees Dental and Vision Insurance Program vision plan with the largest national enrollment as of the first quarter of 2014. The pediatric vision care services covered pursuant to this paragraph shall be in addition to, and shall not replace, any vision services covered under the plan identified in paragraph (2).

(5) With respect to pediatric oral care, the same health benefits for pediatric oral care covered under the dental benefit received by children under the Medi-Cal program as of 2014, including the provision of medically necessary orthodontic care provided pursuant to the federal Children's Health Insurance Program Reauthorization Act of 2009. The pediatric oral care benefits covered pursuant to this paragraph shall be in addition to, and shall not replace, any dental or orthodontic services covered under the plan identified in paragraph (2).

(b) Treatment limitations imposed on health benefits described in this section shall be no greater than the treatment limitations imposed by the corresponding plans identified in subdivision (a), subject to the requirements set forth in paragraph (2) of subdivision (a).

(c) Except as provided in subdivision (d), this section does not permit a health insurer to make substitutions for the benefits required to be covered under this section, regardless of whether those substitutions are actuarially equivalent.

(d) To the extent permitted under Section 1302 of PPACA and any rules, regulations, or guidance issued pursuant to that section, and to the extent that substitution would not create an obligation for the state to defray costs for any individual, an insurer may substitute its prescription drug formulary for the formulary provided under the plan identified in subdivision (a) if the coverage for prescription drugs complies with the sections referenced in clauses (ii) and (iv) of subparagraph (A) of paragraph (2) of subdivision (a) that apply to prescription drugs.

(e) A health insurer, or its agent, producer, or representative, shall not issue, deliver, renew, offer, market, represent, or sell any product, policy, or discount arrangement as compliant with the essential health benefits requirement in federal law, unless it meets all

of the requirements of this section. This subdivision shall be enforced in the same manner as Section 790.03, including through the means specified in Sections 790.035 and 790.05.

(f) This section applies regardless of whether the policy is offered inside or outside the California Health Benefit Exchange created by Section 100500 of the Government Code.

(g) This section does not exempt a health insurer or a health insurance policy from meeting other applicable requirements of law.

(h) This section does not prohibit a policy from covering additional benefits, including, but not limited to, spiritual care services that are tax deductible under Section 213 of the Internal Revenue Code.

(i) Subdivision (a) does not apply to any of the following:

(1) A policy that provides excepted benefits as described in Sections 2722 and 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-21; 42 U.S.C. Sec. 300gg-91).

(2) A policy that qualifies as a grandfathered health plan under Section 1251 of PPACA or any binding rules, regulations, or guidance issued pursuant to that section.

(j) This section shall not be implemented in a manner that conflicts with a requirement of PPACA.

(k) An essential health benefit is required to be provided under this section only to the extent that federal law does not require the state to defray the costs of the benefit.

(l) This section does not obligate the state to incur costs for the coverage of benefits that are not essential health benefits as defined in this section.

(m) An insurer is not required to cover, under this section, changes to health benefits that are the result of statutes enacted on or after December 31, 2011.

(n) (1) The commissioner may adopt emergency regulations implementing this section. The commissioner, on a one-time basis, may readopt any emergency regulation authorized by this section that is the same as, or substantially equivalent to, an emergency regulation previously adopted under this section.

(2) The initial adoption of emergency regulations implementing this section and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(3) The initial adoption of emergency regulations implementing this section made during the 2015–16 Regular Session of the Legislature and the readoption of emergency regulations authorized by this subdivision shall be deemed an emergency and necessary for the immediate preservation of the public peace, health, safety, or general welfare. The initial emergency regulations and the readoption of emergency regulations authorized by this section shall be submitted to the Office of Administrative Law for filing with the Secretary of State and each shall remain in effect for no more than 180 days, by which time final regulations may be adopted.

(4) The commissioner shall consult with the Director of the Department of Managed Health Care to ensure consistency and uniformity in the development of regulations under this subdivision.

(5) This subdivision shall become inoperative on July 1, 2018.

(o) This section does not impose on health insurance policies the cost sharing or network limitations of the plans identified in subdivision (a) except to the extent otherwise required to comply with this code, including this section, and as otherwise applicable to all health insurance policies offered to individuals and small groups.

(p) For purposes of this section, the following definitions apply:

(1) “Habilitative services” means health care services and devices that help a person keep, learn, or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology, and other services for people with disabilities in a variety of inpatient or outpatient settings, or both. Habilitative services shall be covered under the same terms and conditions applied to rehabilitative services under the policy.

(2) (A) “Health benefits,” unless otherwise required to be defined pursuant to federal rules, regulations, or guidance issued pursuant to Section 1302(b) of PPACA, means health care items or services for the diagnosis, cure, mitigation, treatment, or prevention of illness, injury, disease, or a health condition, including a behavioral health condition.

(B) “Health benefits” does not mean any cost-sharing requirements such as copayments, coinsurance, or deductibles.

(3) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(4) “Small group health insurance policy” means a group health insurance policy issued to a small employer, as defined in subdivision (q) of Section 10753.

(Amended by Stats. 2021, Ch. 764, Sec. 7. (SB 326) Effective January 1, 2022.)

10112.28. (a) This section shall apply to nongrandfathered individual and group health insurance policies that provide coverage for essential health benefits, as defined in Section 10112.27, and that are issued, amended, or renewed on or after January 1, 2015.

(b) (1) For nongrandfathered health insurance policies in the individual or small group markets, a health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for all covered benefits that meet the definition of essential health benefits in Section 10112.27, including out-of-network emergency care.

(2) For nongrandfathered health insurance policies in the large group market, a health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2015, shall provide for a limit on annual out-of-pocket expenses for covered benefits, including out-of-network emergency care. This limit shall apply only to essential health benefits, as defined in Section 10112.27, that are covered under the policy to the extent that this provision does not conflict with federal law or guidance on out-of-pocket maximums for nongrandfathered health insurance policies in the large group market.

(c) (1) The limit described in subdivision (b) shall not exceed the limit described in Section 1302(c) of PPACA and any subsequent rules, regulations, or guidance issued under that section.

(2) The limit described in subdivision (b) shall result in a total maximum out-of-pocket limit for all covered essential health benefits that shall equal the dollar amounts in effect under Section 223(c)(2)(A)(ii) of the Internal Revenue Code of 1986 with the dollar amounts adjusted as specified in Section 1302(c)(1)(B) of PPACA.

(3) For family coverage, an individual within a family shall not have a maximum out-of-pocket limit that is greater than the maximum out-of-pocket limit for individual coverage for that product.

(d) Nothing in this section shall be construed to affect the reduction in cost sharing for eligible insureds described in Section 1402 of PPACA and any subsequent rules, regulations, or guidance issued under that section.

(e) If an essential health benefit is offered or provided by a specialized health insurance policy, the total annual out-of-pocket maximum for all covered essential benefits shall not exceed the limit in subdivision (b). This section shall not apply to a specialized health insurance policy that does not offer an essential health benefit as defined in Section 10112.27.

(f) The maximum out-of-pocket limit shall apply to any copayment, coinsurance, deductible, and any other form of cost sharing for all covered benefits that meet the definition of essential health benefits, as defined in Section 10112.27.

(g) (1) (A) Except as provided in paragraph (2), if a health insurance policy for family coverage includes a deductible, an individual within a family shall not have a deductible that is greater than the deductible limit for individual coverage for that product.

(B) Except as provided in paragraph (2), for a large group market health insurance policy for family coverage that is issued, amended, or renewed on or after January 1, 2017, includes a deductible, an individual within a family shall not have a deductible that is greater than the deductible limit for individual coverage for that product.

(2) (A) If a health insurance policy for family coverage includes a deductible and is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the policy shall include a deductible for each individual covered by the policy that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the policy, whichever is greater.

(B) If a large group market health insurance policy for family coverage that is issued, amended, or renewed on or after January 1, 2017, includes a deductible and is a high deductible health plan under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, the policy shall include a deductible for each individual covered by the policy that is equal to either the amount set forth in Section 223(c)(2)(A)(i)(II) of Title 26 of the United States Code or the deductible for individual coverage under the policy, whichever is greater.

(h) For nongrandfathered health insurance policies in the group market, “policy year” has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations. For nongrandfathered health insurance policies sold in the individual market, “policy year” means the calendar year.

(i) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(Amended by Stats. 2015, Ch. 641, Sec. 3. (AB 1305) Effective January 1, 2016.)

10112.281. (a) A large group health insurance policy issued, amended, or renewed on or after July 1, 2022, shall cover medically necessary basic health care services.

(b) “Basic health care services” means all the following:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. “Basic health care services” includes ambulance and ambulance transport services provided through the “911” emergency response system.

(7) Hospice care that is, at a minimum, equivalent to hospice care provided by the federal Medicare Program pursuant to Title XVIII of the Social Security Act (42 U.S.C. Sec. 1395 et seq.) and implementing regulations adopted for hospice care under Title XVIII of the Social Security Act in Part 418 of Chapter IV of Title 42 of the Code of Federal Regulations, except Subparts A, B, G, and H, and any amendments or successor provisions.

(c) “Out-of-area coverage” means coverage while an insured is anywhere outside the service area of the applicable network, and shall also include coverage for urgently needed services to prevent serious deterioration of an insured’s health resulting from unforeseen illness or injury for which treatment cannot be delayed until the insured returns to the service area.

(d) This section does not prohibit a large group health insurance policy from covering additional benefits.

(e) The commissioner may adopt regulations pursuant to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) to implement this section. Prior to adopting regulations, the commissioner shall consult with the Department of Managed Health Care to ensure consistency, to the extent practical, with Section 1300.67 of Title 28 of the California Code of Regulations.

(f) (1) If Section 10112.27 is no longer in effect, this section and any regulations implementing this section shall apply to an individual, group, or blanket disability insurance policy that covers hospital, medical, or surgical benefits, except as provided in subdivision (g).

(2) If the condition described in paragraph (1) occurs, the department shall post notice on its internet website that this section applies to an individual, group, or blanket disability insurance policy that covers hospital, medical, or surgical benefits, and shall provide written notice to the Secretary of the Senate, the Chief Clerk of the Assembly, and the Legislative Counsel.

(g) This section does not apply to a specialized health insurance policy that covers only dental or vision benefits.

(Added by Stats. 2021, Ch. 636, Sec. 1. (SB 280) Effective January 1, 2022.)

10112.282. (a) With respect to large group health insurance, an insurer and its officials, employees, agents, and representatives shall not, directly or indirectly, employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs or discriminating based on an individual’s race, color, national origin, present or predicted disability, age, sex, gender identity, sexual orientation, expected length of life, degree of medical dependency, quality of life, or other health conditions.

(b) An insurer that violates this section shall be liable for an administrative penalty of not more than two thousand five hundred dollars ($2,500) for the first violation, and not more than five thousand dollars ($5,000) for each subsequent violation.

(c) An insurer that violates this section with a frequency that indicates a general business practice or commits a knowing violation of this section shall be liable for an administrative penalty of not less than fifteen thousand dollars ($15,000), and not more than one hundred thousand dollars ($100,000) for each violation.

(d) This section does not apply to a grandfathered large group health insurance policy or a specialized health insurance policy that covers only dental or vision benefits.

(Added by Stats. 2021, Ch. 636, Sec. 2. (SB 280) Effective January 1, 2022.)

10112.29. (a) (1) For a small employer health insurance policy offered, sold, or renewed on or after January 1, 2014, the deductible under the policy shall not exceed:

(A) Two thousand dollars ($2,000) in the case of a policy covering a single individual.

(B) Four thousand dollars ($4,000) in the case of any other policy.

(2) The dollar amounts in this section shall be indexed consistent with Section 1302(c)(4) of PPACA and any federal rules or guidance pursuant to that section.

(3) The limitation in this subdivision shall be applied in a manner that does not affect the actuarial value of any small employer health insurance policy.

(4) For small group products at the bronze level of coverage, as defined in Section 10112.295, the department may permit insurers to offer a higher deductible in order to meet the actuarial value requirement of the bronze level. In making this determination, the department shall consider affordability of cost sharing for insureds and shall also consider whether insureds may be deterred from seeking appropriate care because of higher cost sharing.

(b) Nothing in this section shall be construed to allow a policy to have a deductible that applies to preventive services as defined in PPACA.

(c) This section shall not apply to multiple employer welfare arrangements regulated pursuant to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 that provide health care benefits to their members and that comply with small group health reforms unless otherwise required by federal law or guidance.

(d) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(Amended by Stats. 2015, Ch. 641, Sec. 4. (AB 1305) Effective January 1, 2016.)

10112.291. (a) For a health insurance policy issued, amended, or renewed on or after July 1, 2022, in the individual or group market, a health insurer shall monitor an insured’s accrual toward their annual deductible, if any, for covered benefits, as set forth in this section and any regulations promulgated by the department.

(1) A health insurer shall provide an insured with their accrual balance toward their annual deductible for every month in which benefits were used and until the accrual balance equals the full deductible amount.

(2) A health insurer subject to this section shall establish and maintain a system that allows an insured to request their most up-to-date accrual balance toward their annual deductible from their health insurer at any time.

(3) If the health insurance policy includes more than one annual deductible for an insured, then this section applies to each deductible.

(b) For a health insurance policy issued, amended, or renewed on or after July 1, 2022, in the individual or group market, an insurer shall monitor an insured’s accrual balance toward their annual out-of-pocket maximum, if any, for covered benefits, as set forth in this section and any regulations promulgated by the department.

(1) A health insurer shall provide an insured with their accrual balance toward their annual out-of-pocket maximum for every month in which benefits were used and until the accrual balance equals the full out-of-pocket maximum.

(2) A health insurer subject to this section shall establish and maintain a system that allows an insured to request their most up-to-date accrual balance toward their annual out-of-pocket maximum from their health insurer at any time.

(c) Accrual updates shall be mailed to an insured unless the insured has elected to opt out of mailed notice and elected to receive the accrual update electronically as allowed according to Section 38.6, or unless the insured has previously opted out of mailed notices.

(1) Insureds who have opted out of receiving mailed notice may opt back in at any time.

(2) Accrual updates may be included with evidence of benefit statements.

(d) A health insurer shall notify insureds of their rights pursuant to this section, including, but not limited to, how to request information and how to opt out of mailed notices and elect to instead receive their accrual update electronically, in the manner set forth by the department. The department may issue guidance regarding implementation of, and compliance with, this subdivision. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 1340) of Part 1 of Division 3 of Title 2 of the Government Code), until January 1, 2027. The department shall consult with stakeholders in developing guidance pursuant to this subdivision.

(e) If a health insurer delegates claims payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, the delegated entity shall comply with the requirements of this section. A health insurer shall specify by contract the delegated entity's responsibilities and shall monitor the delegated entity to ensure compliance with this section. Notwithstanding delegation pursuant to this subdivision, the health insurer shall remain responsible for compliance with this section.

(Added by Stats. 2021, Ch. 602, Sec. 2. (SB 368) Effective January 1, 2022.)

10112.295. (a) Levels of coverage for the nongrandfathered individual market are defined as follows:

(1) Bronze level: A health insurance policy in the bronze level shall provide a level of coverage that is actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the policy.

(2) Silver level: A health insurance policy in the silver level shall provide a level of coverage that is actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the policy.

(3) Gold level: A health insurance policy in the gold level shall provide a level of coverage that is actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the policy.

(4) Platinum level: A health insurance policy in the platinum level shall provide a level of coverage that is actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the policy.

(b) Actuarial value for nongrandfathered individual health insurance policies shall be determined in accordance with the following:

(1) Actuarial value shall not vary by more than plus or minus 2 percent.

(2) Actuarial value shall be determined on the basis of essential health benefits as defined in Section 10112.27 and as provided to a standard, nonelderly population. For this purpose, a standard population shall not include those receiving coverage through the Medi-Cal or Medicare programs.

(3) The department may use the actuarial value methodology developed consistent with Section 1302(d) of PPACA.

(4) The actuarial value for pediatric dental benefits, whether offered by a major medical policy or a specialized health insurance policy, shall be consistent with federal law and guidance applicable to the policy type.

(5) The department, in consultation with the Department of Managed Health Care and the Exchange, shall consider whether to exercise state-level flexibility with respect to the actuarial value calculator in order to take into account the unique characteristics of the California health care coverage market, including the prevalence of health insurance policies, total cost of care paid for by the health insurer, price of care, patterns of service utilization, and relevant demographic factors.

(c) (1) A catastrophic policy is a health insurance policy that provides no benefits for any plan year until the insured has incurred cost-sharing expenses in an amount equal to the annual limit on out-of-pocket costs as specified in Section 10112.28 except that it shall provide coverage for at least three primary care visits. A carrier that is not participating in the Exchange shall not offer, market, or sell a catastrophic plan in the individual market.

(2) A catastrophic policy may be offered only in the individual market and only if consistent with this paragraph. Catastrophic policies may be offered only if either of the following apply:

(A) The individual purchasing the policy has not yet attained 30 years of age before the beginning of the plan year.

(B) The individual has a certificate of exemption from Section 5000(A) of the Internal Revenue Code because the individual is not offered affordable coverage or because the individual faces hardship.

(d) This section shall apply to a policy of health insurance, as defined in subdivision (b) of Section 106, that covers any essential health benefit as defined in Section 10112.27. This section shall not apply to a specialized health insurance policy that does not cover any of the essential health benefits.

(e) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(Added by Stats. 2013, Ch. 316, Sec. 12. (SB 639) Effective January 1, 2014.)

10112.296. Notwithstanding paragraph (1) of subdivision (b) of Section 10112.295 and paragraph (1) of subdivision (b) of Section 10112.297, the actuarial value for a nongrandfathered bronze level health insurance policy that either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, may range from plus 5 percent to minus 2 percent.

(Amended by Stats. 2020, Ch. 12, Sec. 36. (AB 80) Effective June 29, 2020.)

10112.297. (a) Levels of coverage for the nongrandfathered small group market are defined as follows:

(1) Bronze level: A health insurance policy in the bronze level shall provide a level of coverage that is actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the policy.

(2) Silver level: A health insurance policy in the silver level shall provide a level of coverage that is actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the policy.

(3) Gold level: A health insurance policy in the gold level shall provide a level of coverage that is actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the policy.

(4) Platinum level: A health insurance policy in the platinum level shall provide a level of coverage that is actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the policy.

(b) Actuarial value for nongrandfathered small employer health insurance policies shall be determined in accordance with the following:

(1) Actuarial value shall not vary by more than plus or minus 2 percent.

(2) Actuarial value shall be determined on the basis of essential health benefits as defined in paragraph (1) of subdivision (a) of Section 10112.27 and as provided to a standard, nonelderly population. For this purpose, a standard population shall not include those receiving coverage through the Medi-Cal or Medicare programs.

(3) The department may use the actuarial value methodology developed consistent with Section 1302(d) of PPACA.

(4) The actuarial value for pediatric dental benefits, whether offered by a major medical policy or a specialized health insurance policy, shall be consistent with federal law and guidance applicable to the policy type.

(5) The department, in consultation with the Department of Managed Health Care and the Exchange, shall consider whether to exercise state-level flexibility with respect to the actuarial value calculator in order to take into account the unique characteristics of the California health care coverage market, including the prevalence of health insurance policies, total cost of care paid for by the health insurer, price of care, patterns of service utilization, and relevant demographic factors.

(6) Employer contributions toward health reimbursement accounts and health savings accounts shall count toward the actuarial value of the product in the manner specified in federal rules and guidance.

(c) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(Added by Stats. 2013, Ch. 316, Sec. 13. (SB 639) Effective January 1, 2014.)

10112.3. (a) For purposes of this section, the following definitions shall apply:

(1) “Exchange” means the California Health Benefit Exchange established in Title 22 (commencing with Section 100500) of the Government Code.

(2) “Federal act” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance

issued under, those acts.

(3) “Qualified health plan” has the same meaning as that term is defined in Section 1301 of the federal act.

(4) “Small employer” has the same meaning as that term is defined in Section 10753.

(b) (1) Health insurers participating in the individual market of the Exchange shall fairly and affirmatively offer, market, and sell in the individual market of the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act. Health insurers participating in the Small Business Health Options Program (SHOP Program) of the Exchange, established pursuant to subdivision (m) of Section 100504 of the Government Code, shall fairly and affirmatively offer, market, and sell in the SHOP Program at least one product within each of the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(2) The board established under Section 100500 of the Government Code may require insurers to sell additional products within each of the levels of coverage identified in paragraph (1).

(3) This subdivision shall not apply to an insurer that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504 of the Government Code. This subdivision shall not apply to a bridge plan product of a Medi-Cal managed care plan that contracts with the State Department of Health Care Services pursuant to Section 14005.70 of the Welfare and Institutions Code and that meets the requirements of Section 100504.5 of the Government Code, to the extent approved by the appropriate federal agency.

(c) (1) Health insurers participating in the Exchange that sell any products outside the Exchange shall do both of the following:

(A) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(B) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(2) For purposes of this subdivision, “product” does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 between the Managed Risk Medical Insurance Board and health insurers for enrolled Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the State Department of Health Care Services and health insurers for enrolled Medi-Cal beneficiaries or for contracts with bridge plan products that meet the requirements of Section 100504.5 of the Government Code.

(d) (1) Commencing January 1, 2014, a health insurer shall, with respect to individual policies that cover hospital, medical, or surgical benefits, only sell the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act, except that a health insurer that does not participate in the Exchange shall, with respect to individual policies that cover hospital, medical, or surgical benefits, only sell the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(2) Commencing January 1, 2014, a health insurer shall, with respect to small employer policies that cover hospital, medical, or surgical expenses, only sell the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(e) Commencing January 1, 2014, a health insurer that does not participate in the Exchange shall, with respect to individual or small employer policies that cover hospital, medical, or surgical expenses, offer at least one standardized product that has been designated by the Exchange in each of the four levels of coverage contained in subsection (d) of Section 1302 of the federal act. This subdivision shall only apply if the board of the Exchange exercises its authority under subdivision (c) of Section 100504 of the Government Code. Nothing in this subdivision shall require an insurer that does not participate in the Exchange to offer standardized products in the small employer market if the insurer only sells products in the individual market. Nothing in this subdivision shall require an insurer that does not participate in the Exchange to offer standardized products in the individual market if the insurer only sells products in the small employer market. This subdivision shall not be construed to prohibit the insurer from offering other products provided that it complies with subdivision (d).

(f) For purposes of this section, a bridge plan product shall mean an individual health benefit plan, as defined in subdivision (a) of Section 10198.6 that is offered by a health insurer that contracts with the Exchange pursuant to Section 100504.5 of the Government Code.

(g) This section shall become inoperative on the October 1 that is five years after the date that federal approval of the bridge plan option occurs, and, as of the second January 1 thereafter, is repealed, unless a later enacted statute that is enacted before that date deletes or extends the dates on which it becomes inoperative and is repealed.

(Amended (as amended by Stats. 2013, 1st Ex. Sess., Ch. 5, Sec. 11) by Stats. 2014, Ch. 572, Sec. 16. (SB 959) Effective January 1, 2015. Conditionally inoperative, on date prescribed by its own provisions. Repealed, by its own provisions, on second January 1 after inoperative date. See later operative version, as amended by Sec. 17 of Stats. 2014, Ch. 572.)

10112.3. (a) For purposes of this section, the following definitions shall apply:

(1) “Exchange” means the California Health Benefit Exchange established in Title 22 (commencing with Section 100500) of the Government Code.

(2) “Federal act” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments to, or regulations or guidance issued under, those acts.

(3) “Qualified health plan” has the same meaning as that term is defined in Section 1301 of the federal act.

(4) “Small employer” has the same meaning as that term is defined in Section 10753.

(b) (1) Health insurers participating in the individual market of the Exchange shall fairly and affirmatively offer, market, and sell in the individual market of the Exchange at least one product within each of the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act. Health insurers participating in the Small Business Health Options Program (SHOP Program) of the Exchange, established pursuant to subdivision (m) of Section 100504 of the Government Code, shall fairly and affirmatively offer, market, and sell in the SHOP Program at least one product within each of the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(2) The board established under Section 100500 of the Government Code may require insurers to sell additional products within each of the levels of coverage identified in paragraph (1).

(3) This subdivision shall not apply to an insurer that solely offers supplemental coverage in the Exchange under paragraph (10) of subdivision (a) of Section 100504 of the Government Code.

(c) (1) Health insurers participating in the Exchange that sell any products outside the Exchange shall do both of the following:

(A) Fairly and affirmatively offer, market, and sell all products made available to individuals in the Exchange to individuals purchasing coverage outside the Exchange.

(B) Fairly and affirmatively offer, market, and sell all products made available to small employers in the Exchange to small employers purchasing coverage outside the Exchange.

(2) For purposes of this subdivision, “product” does not include contracts entered into pursuant to Part 6.2 (commencing with Section 12693) of Division 2 between the Managed Risk Medical Insurance Board and health insurers for enrolled Healthy Families beneficiaries or to contracts entered into pursuant to Chapter 7 (commencing with Section 14000) of, or Chapter 8 (commencing with Section 14200) of, Part 3 of Division 9 of the Welfare and Institutions Code between the State Department of Health Care Services and health insurers for enrolled Medi-Cal beneficiaries.

(d) (1) Commencing January 1, 2014, a health insurer shall, with respect to individual policies that cover hospital, medical, or surgical benefits, only sell the five levels of coverage contained in subsections (d) and (e) of Section 1302 of the federal act, except that a health insurer that does not participate in the Exchange shall, with respect to individual policies that cover hospital, medical, or surgical benefits, only sell the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(2) Commencing January 1, 2014, a health insurer shall, with respect to small employer policies that cover hospital, medical, or surgical expenses, only sell the four levels of coverage contained in subsection (d) of Section 1302 of the federal act.

(e) Commencing January 1, 2014, a health insurer that does not participate in the Exchange shall, with respect to individual or small employer policies that cover hospital, medical, or surgical expenses, offer at least one standardized product that has been designated by the Exchange in each of the four levels of coverage contained in subsection (d) of Section 1302 of the federal act. This subdivision shall only apply if the board of the Exchange exercises its authority under subdivision (c) of Section 100504 of the Government Code. Nothing in this subdivision shall require an insurer that does not participate in the Exchange to offer standardized products in the small employer market if the insurer only sells products in the individual market. Nothing in this subdivision shall require an insurer that does not participate in the Exchange to offer standardized products in the individual market if the insurer only sells products in the small employer market. This subdivision shall not be construed to prohibit the insurer from offering other products provided that it complies with subdivision (d).

(f) This section shall become operative only if Section 11 of the act that added this section becomes inoperative pursuant to subdivision (g) of that Section 11.

(Amended (as added by Stats. 2013, 1st Ex. Sess., Ch. 5, Sec. 12) by Stats. 2014, Ch. 572, Sec. 17. (SB 959) Effective January 1, 2015. Section conditionally operative by its own provisions.)

10112.300. (a) (1) A small employer health benefit plan in effect on December 31, 2013, and still in effect as of the effective date of this section, that does not qualify as a grandfathered health plan under Section 1251 of PPACA may be renewed until January 1, 2015, and may continue to be in force until December 31, 2015, subject to applicable federal law, and any other requirements imposed by this part.

(2) A small employer health benefit plan described in paragraph (1) may continue to be in force after December 31, 2015, if the plan is amended to comply with all of the provisions listed in subdivision (e) by January 1, 2016, and complies with all other applicable provisions of law.

(b) (1) If an insurer offers for renewal a small employer health benefit plan pursuant to paragraph (1) of subdivision (a), the insurer shall provide notice to the group contractholder regarding the option to renew coverage pursuant to subdivision (a) using the relevant notice attached to the guidance entitled "Insurance Standards Bulletin Series – Extension of Transition Policy through October 1, 2016," issued by the United States Department of Health and Human Services, Centers for Medicare and Medicaid Services on March 5, 2014.

(2) An insurer shall include the following notice with the notice issued pursuant to paragraph (1):

"New health care coverage options are available in California. You currently have health care coverage that is not required to comply with many new laws. A new health benefit plan may be more affordable and/or offer more comprehensive benefits. New plans may also have limits on deductibles and out-of-pocket costs, while your existing plan may have no such limits.

You have the option to remain with your current coverage for one more year or switch to new coverage that complies with the new laws. Covered California, the state's new health insurance marketplace, offers small employers health insurance from a number of companies through its Small Business Health Options Program (SHOP). Federal tax credits are available through the SHOP to those small employers that qualify. Talk to Covered California (1-877-453-9198), your plan representative, or your insurance agent to discuss your options."

(3) An insurer shall include with the notices issued pursuant to paragraphs (1) and (2), the premium, cost sharing, and benefits associated with the plan's standard benefit designs approved consistent with subdivision (c) of Section 100504 of the Government Code for the geographic region of the small employer.

(4) An insurer that offers for renewal a small employer health benefit plan pursuant to paragraph (1) of subdivision (a) shall offer renewal to all employers whose health benefit plan with that insurer was in effect on December 31, 2013.

(c) (1) A small employer health benefit plan in effect on December 31, 2013, and still in effect as of the effective date of this section, that does not qualify as a grandfathered health plan under Section 1251 of PPACA that is renewed on or before January 1, 2015, and that continues to be in force until no later than December 31, 2015, is exempt from the following provisions:

(A) Paragraph (1) of subdivision (b) of, and subdivisions (c), (g), and (k) of, Section 10753.05.

(B) Section 10753.14.

(C) Section 10112.27.

(D) Section 10112.285.

(E) Section 10112.28.

(F) Section 10112.29.

(G) Section 10112.297.

(2) Notwithstanding paragraph (1) of subdivision (b) of, and subdivision (g) of, Section 10753.05, a small employer health benefit plan subject to this section shall only be offered, marketed, and sold to an employer whose health benefit plan with that insurer was in effect on December 31, 2013.

(d) A small employer health benefit plan described in paragraph (1) of subdivision (a) shall be subject to Sections 10714 and 10715, and shall continue to be subject to Chapter 8.01 (commencing with Section 10753), except as provided in subdivision (c), and to all

otherwise applicable provisions of this part.

(e) No later than January 1, 2016, a small employer health benefit plan described in paragraph (1) of subdivision (a) may be amended to comply with all of the following:

(1) Paragraph (1) of subdivision (b) of, and subdivisions (c), (g), and (k) of, Section 10753.05.

(2) Section 10753.14.

(3) Section 10112.27.

(4) Section 10112.28.

(5) Section 10112.29.

(6) Section 10112.297.

(f) This section shall be implemented only to the extent permitted by PPACA.

(g) For purposes of this section, the following definitions shall apply:

(1) “Health benefit plan” has the same meaning as defined in subdivision (j) of Section 10753.

(2) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

(3) “Small employer health benefit plan” means a group health benefit plan issued to a small employer, as defined in Section 10753.

(Added by Stats. 2014, Ch. 84, Sec. 2. (SB 1446) Effective July 7, 2014.)

10112.35. (a) An insurer providing individual coverage in the Exchange shall cooperate with requests from the Exchange to collaborate in the development of, and participate in the implementation of, the Medi-Cal program’s premium and cost-sharing payments under Sections 14102 and 14148.65 of the Welfare and Institutions Code for eligible Exchange insureds.

(b) An insurer providing individual coverage in the Exchange shall not charge, bill, ask, or require an insured receiving benefits under Section 14102 or 14148.65 of the Welfare and Institutions Code to make any premium or cost-sharing payments for any services that are subject to premium or cost-sharing payments by the State Department of Health Care Services under Section 14102 or 14148.65 of the Welfare and Institutions Code.

(c) For purposes of this section, “Exchange” means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(Amended by Stats. 2015, Ch. 303, Sec. 368. (AB 731) Effective January 1, 2016.)

10112.4. The commissioner shall, in coordination with the Director of the Department of Managed Health Care, review the Internet portal developed by the United States Secretary of Health and Human Services under subdivision (a) of Section 1103 of the federal Patient Protection and Affordable Care Act (P.L. 111-148) and paragraph (5) of subdivision (c) of Section 1311 of that act, and any enhancements to that portal expected to be implemented by the secretary on or before January 1, 2015. The review shall examine whether the Internet portal provides sufficient information regarding all health benefit products offered by health care service plans and health insurers in the individual and small employer markets in California to facilitate fair and affirmative marketing of all individual and small employer products, particularly outside the California Health Benefit Exchange created under Title 22 (commencing with Section 100500) of the Government Code. If the commissioner and the Director of the Department of Managed Health Care jointly determine that the Internet portal does not adequately achieve those purposes, they shall jointly develop and maintain an electronic clearinghouse to achieve those purposes. In performing this function, the commissioner and the Director of the Department of Managed Health Care shall routinely monitor individual and small employer benefit filings with, and complaints submitted by individuals and small employers to, their respective departments, and shall use any other available means to maintain the clearinghouse.

(Amended by Stats. 2011, Ch. 296, Sec. 186. (AB 1023) Effective January 1, 2012.)

10112.5. (a) (1) Notwithstanding any other provision of law, every policy or certificate of health insurance marketed, issued, or delivered to a resident of this state, regardless of the situs of the contract or master group policyholder, shall be subject to all provisions of this code.

(2) (A) Paragraph (1) shall not apply to a policy or certificate of health insurance that is issued outside of California to an employer whose principal place of business and majority of employees are located outside of California.

(B) Notwithstanding subparagraph (A), no policy or certificate of health insurance marketed, issued, or delivered to a resident of this state shall discriminate in coverage between spouses or domestic partners of a different sex and spouses or domestic partners of the same sex.

(3) Nothing in subparagraph (A) of paragraph (2) shall be construed to limit the applicability of any other provision of this code to any policy or certificate of health insurance that is issued outside of California to an employer whose principal place of business and majority of employees are located outside of California.

(b) Notwithstanding any other provision of law, every policy or certificate of group health insurance marketed, issued, or delivered to a resident of this state, regardless of the situs of the contract or master group policyholder, shall be subject to Section 10121.7.

(Amended by Stats. 2011, Ch. 722, Sec. 3. (SB 757) Effective January 1, 2012.)

10112.6. (a) Consistent with federal law, a sponsor of a prescription drug plan authorized by the federal Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) shall hold a valid license as a life and disability insurer issued by the department or as a health care service plan issued by the Department of Managed Health Care.

(b) An entity that is licensed as a life and disability insurer and that operates a prescription drug plan shall be subject to the provisions of this code, unless preempted by federal law.

(Added by Stats. 2005, Ch. 230, Sec. 2. Effective September 6, 2005.)

10112.7. (a) A group or individual health insurance policy issued, amended, or renewed on or after January 1, 2014, that provides or covers any benefits with respect to services in an emergency department of a hospital shall cover emergency services as follows:

(1) Without the need for any prior authorization determination.

(2) Whether the health care provider furnishing the services is a participating provider with respect to those services.

(3) In a manner so that, if the services are provided to an insured:

(A) By a nonparticipating health care provider with or without prior authorization; or

(B) (i) The services will be provided without imposing any requirement under the policy for prior authorization of services or any limitation on coverage where the provider of services does not have a contractual relationship with the insurer for the providing of services that is more restrictive than the requirements or limitations that apply to emergency department services received from providers who do have such a contractual relationship with the insurer; and

(ii) If the services are provided to an insured out-of-network, the cost-sharing requirement, expressed as a copayment amount or coinsurance rate, is the same requirement that would apply if the services were provided in-network.

(b) For the purposes of this section, the term “emergency services” means, with respect to an emergency medical condition:

(1) A medical screening examination that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate that emergency medical condition.

(2) Within the capabilities of the staff and facilities available at the hospital, further medical examination and treatment as are required under Section 1867(e)(3) of the federal Social Security Act (42 U.S.C. 1395dd(e)(3)) to stabilize the patient.

(Added by Stats. 2013, Ch. 316, Sec. 14. (SB 639) Effective January 1, 2014.)

10112.75. (a) If a health insurer sends payment for services provided directly to the insured and not to the provider, the insurer shall send notice to the insured and the provider who provided the services that the insurer has sent payment to the insured.

(b) The notice sent to the insured pursuant to subdivision (a) shall include all of the following:

(1) The date the notice was sent and the name and address of the provider who billed for the service.

(2) A statement that if the insured has paid the full bill for the service, including both their cost-sharing and the insurer share of cost obligation, the actions described to collect the insurer obligated payment in paragraph (3) do not apply, and that this check is for reimbursement of the consumer for paying the insurer share of cost obligation.

(3) Information about action that may be taken if the insured does not send the insurer’s obligated payment to the provider, including all of the following:

(A) That an unpaid bill may be sent to collections and the insured may be subject to collections.

(B) That the provider or debt collector may pursue litigation against the insured to collect the bill.

(C) That the unpaid insurer share of cost obligation may be reported to a credit reporting agency as medical debt if the provider does not receive the payment within 60 days of the notice, or within one year after initial billing for the service, whichever is later.

(c) The required notice sent to the provider pursuant to subdivision (a) shall include the date that the notice to the insured was sent and the amount sent to the insured to reimburse the provider.

(d) If the provider does not receive the payment from the insured within 60 days of the notice to the insured, or within one year after initial billing for the service, whichever is later, the insurer's share of cost in possession of the insured that has not been paid to the provider may be reported to a credit reporting agency as medical debt and shall not be considered medical debt for purposes of Sections 1785.13, 1785.20.6, 1785.27, and 1786.18 of the Civil Code if both of the following are true:

(1) The entity reporting the information has adequate documentation to substantiate that the insured actually received the funds from the insurer.

(2) The insured has not raised a dispute with the insurer, provider, or department as to whether the amount was received.

(e) This section does not limit existing requirements under this chapter protecting insureds from balance billing, including Sections 10112.8 and 10126.66.

(f) This section does not apply if the direct payment for services provided to the insured is a reimbursement from the insurer because the insured paid the insurer's share of cost obligation.

(Added by Stats. 2024, Ch. 520, Sec. 11. (SB 1061) Effective January 1, 2025.)

10112.8. (a) (1) Except as provided in subdivision (c), a health insurance policy issued, amended, or renewed on or after July 1, 2017, that provides benefits through contracts with providers at alternative rates of payment pursuant to Section 10133, shall provide that if an insured receives covered services from a contracting health facility at which, or as a result of which, the insured receives services provided by a noncontracting individual health professional, the insured shall pay no more than the same cost sharing that the insured would pay for the same covered services received from a contracting individual health professional. This amount shall be referred to as the "in-network cost-sharing amount."

(2) Except as provided in subdivision (c), an insured shall not owe the noncontracting individual health professional more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the insurer to the noncontracting individual health professional, the insurer shall inform the insured and the noncontracting individual health professional of the in-network cost-sharing amount owed by the insured.

(3) A noncontracting individual health professional shall not bill or collect any amount from the insured for services subject to this section except the in-network cost-sharing amount. Any communication from the noncontracting individual health professional to the insured prior to the receipt of information about the in-network cost-sharing amount pursuant to paragraph (2) shall include a notice in 12-point bold type stating that the communication is not a bill and informing the insured that the insured shall not pay until they are informed by their insurer of any applicable cost sharing.

(4) (A) If the noncontracting individual health professional has received more than the in-network cost-sharing amount from the insured for services subject to this section, the noncontracting individual health professional shall refund any overpayment to the insured within 30 calendar days after receiving payment from the insured.

(B) If the noncontracting individual health professional does not refund any overpayment to the insured within 30 calendar days after being informed of the insured's in-network cost-sharing amount, interest shall accrue at the rate of 15 percent per annum beginning with the date payment was received from the insured.

(C) A noncontracting individual health professional shall automatically include in their refund to the insured all interest that has accrued pursuant to this section without requiring the insured to submit a request for the interest amount.

(b) Except for services subject to subdivision (c), the following shall apply:

(1) Any cost sharing paid by the insured for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting individual health professional.

(3) The cost sharing paid by the insured pursuant to this section shall satisfy the insured's obligation to pay cost sharing for the health service and shall constitute "applicable cost sharing owed by the insured."

(c) For services subject to this section, if an insured has an insurance contract that includes coverage for out-of-network benefits, a noncontracting individual health professional may bill or collect from the insured the out-of-network cost sharing, if applicable, only when the insured consents in writing and that written consent demonstrates satisfaction of all the following criteria:

(1) At least 24 hours in advance of care, the insured shall consent in writing to receive services from the identified noncontracting individual health professional.

(2) The consent shall be obtained by the noncontracting individual health professional in a document that is separate from the document used to obtain the consent for any other part of the care or procedure. The consent shall not be obtained by the facility or any representative of the facility. The consent shall not be obtained at the time of admission or at any time when the enrollee is being prepared for surgery or any other procedure.

(3) At the time consent is provided the noncontracting individual health professional shall give the insured a written estimate of the insured's total out-of-pocket cost of care. The written estimate shall be based on the professional's billed charges for the service to be provided. The noncontracting individual health professional shall not attempt to collect more than the estimated amount without receiving separate written consent from the insured or the insured's authorized representative, unless circumstances arise during delivery of services that were unforeseeable at the time the estimate was given that would require the provider to change the estimate.

(4) The consent shall advise the insured that they may elect to seek care from a contracted provider or may contact the insured's insurer in order to arrange to receive the health service from a contracted provider for lower out-of-pocket costs.

(5) The consent and estimate shall be provided to the insured in the language spoken by the insured, if the language is a Medi-Cal threshold language, as defined in subdivision (d) of Section 128552 of the Health and Safety Code.

(6) The consent shall also advise the insured that any costs incurred as a result of the insured's use of the out-of-network benefit shall be in addition to in-network cost-sharing amounts and may not count toward the annual out-of-pocket maximum on in-network benefits or a deductible, if any, for in-network benefits.

(d) A noncontracting individual health professional who fails to comply with provisions of this subdivision has not obtained written consent for purposes of this section. Under those circumstances, subdivisions (a) and (b) shall apply and subdivision (c) shall not apply.

(e) (1) A noncontracting individual health professional may advance to collections only the in-network cost-sharing amount, as determined by the insurer pursuant to subdivision (a) or the out-of-network cost-sharing amount owed pursuant to subdivision (c), that the insured has failed to pay.

(2) The noncontracting individual health professional, or any entity acting on their behalf, including any assignee of the debt, shall not do either of the following:

(A) Report adverse information to a consumer credit reporting agency.

(B) Commence civil action against the insured for a minimum of 150 days after the initial billing regarding amounts owed by the insured under subdivision (a) or (c).

(3) With respect to an insured, a noncontracting individual health professional, or any entity acting on their behalf, including any assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills under this section.

(f) For purposes of this section and Sections 10112.81 and 10112.82, the following definitions shall apply:

(1) "Contracting health facility" means a health facility that is contracted with the insured's health insurer to provide services under the insured's policy. A contracting health care facility includes, but is not limited to, the following providers:

(A) A licensed hospital.

(B) An ambulatory surgery or other outpatient setting, as described in subdivision (a), (d), (e), (g), or (h) of Section 1248.1 of the Health and Safety Code.

(C) A laboratory.

(D) A radiology or imaging center.

(2) “Cost sharing” includes any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the insured other than premium or share of premium.

(3) “Individual health professional” means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services. For this purpose, an “individual health professional” shall not include a dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code).

(4) “In-network cost-sharing amount” means an amount no more than the same cost sharing the insured would pay for the same covered service received from a contracting health professional. The in-network cost-sharing amount with respect to an insured with coinsurance shall be based on the amount paid by the insurer pursuant to paragraph (1) of subdivision (a) of Section 10112.82.

(5) “Noncontracting individual health professional” means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services and who is not contracted with the insured’s health insurance product. For this purpose, a “noncontracting individual health professional” shall not include a dentist, licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code). Application of this definition is not precluded by a noncontracting individual health professional’s affiliation with a group.

(g) This section shall not be construed to require an insurer to cover services not required by law or by the terms and conditions of the health insurance policy.

(h) If a health insurer delegates payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, the delegated entity shall comply with this section.

(i) This section shall not apply to emergency services and care, as defined in Section 1317.1 of the Health and Safety Code.

(Amended by Stats. 2024, Ch. 520, Sec. 12. (SB 1061) Effective January 1, 2025.)

10112.81. (a) (1) By September 1, 2017, the commissioner shall establish an independent dispute resolution process for the purpose of processing and resolving a claim dispute between a health insurer and a noncontracting individual health professional for services subject to subdivision (a) of Section 10112.8.

(2) Prior to initiating the independent dispute resolution process, the parties shall complete the insurer’s internal process.

(3) If either the noncontracting individual health professional or the insurer appeals a claim to the department’s independent dispute resolution process, the other party shall participate in the appeal process as described in this section.

(b) (1) The commissioner shall establish uniform written procedures for the submission, receipt, processing, and resolution of claim payment disputes pursuant to this section and any other guidelines for implementing this section. These procedures shall include a process for each party to submit into evidence information that will be kept confidential from the other party, in order to preserve the confidentiality of the source contract.

(2) The commissioner shall establish reasonable and necessary fees for the purpose of administering this section, to be paid by both parties.

(3) In establishing the independent dispute resolution process, the commissioner shall permit the bundling of claims submitted to the same insurer or the same delegated entity for the same or similar services by the same noncontracting individual health professional.

(4) The commissioner shall permit a physician group, independent practice association, or other entity authorized to act on behalf of a noncontracting individual health professional to initiate and participate in the independent dispute resolution process.

(5) (A) In deciding the dispute, the independent organization shall conduct a de novo review and base its decision regarding the appropriate reimbursement on the information and documents timely submitted into evidence by the parties to the dispute.

(B) The independent organization shall assign reviewers to each case based on their relevant education, background, and medical claims payment and clinical experience.

(c) (1) The commissioner may contract with one or more independent organizations to conduct the proceedings. The independent organization handling a dispute shall be independent of either party to the dispute.

(2) The commissioner shall establish conflict-of-interest standards, consistent with the purposes of this section, that an organization shall meet in order to qualify to administer the independent dispute resolution program. The conflict-of-interest standards shall be consistent with the standards pursuant to subdivisions (c) and (d) of Section 10169.2.

(3) The commissioner may contract with the same independent organization or organizations as the State Department of Managed Health Care.

(4) The commissioner shall provide, upon the request of an interested person, a copy of all nonproprietary information, as determined by the commissioner, filed with the department by an independent organization seeking to contract with the department to administer the independent dispute resolution process pursuant to this section. The department may charge a nominal fee to cover the costs of providing a copy of the information pursuant to this paragraph.

(5) Contracts entered into pursuant to the authority in this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of the Government Code and shall be exempt from the review or approval of any division of the Department of General Services.

(d) The decision obtained through the commissioner's independent dispute resolution process shall be binding on both parties. The insurer shall implement the decision obtained through the independent dispute resolution process. If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law.

(e) If a health insurer delegates payment functions to a contracted entity, including, but not limited to, a medical group or independent practice association, then the delegated entity shall comply with this section.

(f) This section shall not apply to emergency services and care, as defined in Section 1317.1 of the Health and Safety Code.

(g) The definitions in subdivision (f) of Section 10112.8 shall apply for purposes of this section.

(h) This section shall not be construed to alter a health insurer's obligations pursuant to Section 10123.13.

(i) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the commissioner may implement, interpret, or make specific this section by issuing guidance, without taking regulatory action, until the time regulations are adopted.

(j) By January 1, 2019, the commissioner shall provide a report to the Governor, the President pro Tempore of the Senate, the Speaker of the Assembly, and the Senate and Assembly Committees on Health of the data and information provided in the independent dispute resolution process in a manner and format specified by the Legislature.

(Amended by Stats. 2020, Ch. 278, Sec. 2. (AB 2157) Effective January 1, 2021.)

10112.82. (a) (1) For services rendered subject to Section 10112.8, effective July 1, 2017, unless otherwise agreed to by the noncontracting individual health professional and the insurer, the insurer shall reimburse the greater of the average contracted rate or 125 percent of the amount Medicare reimburses on a fee-for-service basis for the same or similar services in the general geographic region in which the services were rendered. For the purposes of this section, "average contracted rate" means the average of the contracted commercial rates paid by the health insurer for the same or similar services in the geographic region. This subdivision does not apply to subdivision (c) of Section 10112.8 or subdivision (b) of this section.

(2) (A) By July 1, 2017, each health insurer shall provide to the commissioner all of the following:

(i) Data listing its average contracted rates for the insurer for services most frequently subject to Section 10112.8 in each geographic region in which the services are rendered for the calendar year 2015.

(ii) Its methodology for determining the average contracted rate for the insurer for services subject to Section 10112.8. The methodology to determine an average contracted rate shall ensure that the insurer includes the highest and lowest contracted rates for the calendar year 2015.

(iii) The policies and procedures used to determine the average contracted rates under this subdivision.

(B) For each calendar year after the health insurer's initial submission of the average contracted rate as specified in subparagraph (A) and until the standardized methodology under paragraph (3) is specified, a health insurer shall adjust the rate initially established pursuant to this subdivision by the Consumer Price Index for Medical Care Services, as published by the United States Bureau of Labor Statistics.

(3) (A) By January 1, 2019, the commissioner shall specify a methodology that insurers shall use to determine the average contracted rates for services most frequently subject to Section 10112.8. This methodology shall take into account, at a minimum, information from the independent dispute resolution process, the specialty of the individual health professional, and the geographic region in which the services are rendered. The methodology to determine an average contracted rate shall ensure that the insurer includes the highest and lowest contracted rates.

(B) Insurers shall provide to the commissioner the policies and procedures used to determine the average contracted rates in compliance with subparagraph (A).

(C) The average contracted rate data submitted pursuant to this section shall be confidential and not subject to disclosure under the California Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code).

(D) In developing the standardized methodology under this subdivision, the commissioner shall consult with interested parties throughout the process of developing the standards, including the Department of Managed Health Care, representatives of health plans, insurers, health care providers, hospitals, consumer advocates, and other stakeholders it deems appropriate. The commissioner shall hold the first stakeholder meeting no later than July 1, 2017.

(4) A health insurer shall include in its reports submitted to the commissioner pursuant to Section 10133.5 and regulations adopted pursuant to that section, in a manner specified by the department, the number of payments made to noncontracting individual health professionals for services at a contracting health facility and subject to Section 10112.8, as well as other data sufficient to determine the proportion of noncontracting individual health professionals to contracting individual health professionals at contracting health facilities, as defined in subdivision (f) of Section 10112.8. The commissioner shall include a summary of this information in its January 1, 2019, report required pursuant to subdivision (j) of Section 10112.81 and its findings regarding the impact of the act that added this section on health insurer contracting and network adequacy.

(5) A health insurer that provides services subject to Section 10112.8 shall meet the network adequacy requirements set forth in this chapter, including, but not limited to, Section 10133.5 of this code and Sections 2240.1 and 2240.7 of Title 10 of the California Code of Regulations, including, but not limited to, inpatient hospital services and specialist physician services, and if necessary, the commissioner may adopt additional regulations related to those services. This section shall not be construed to limit the commissioner's authority under this chapter.

(6) For the purposes of this section, for average contracted rates for individual and small group coverage, geographic region shall be the geographic regions listed in subparagraph (A) of paragraph (2) of subdivision (a) of Section 10753.14. For purposes of this section for Medicare fee-for-service reimbursement, geographic regions shall be the geographic regions specified for physician reimbursement for Medicare fee-for-service by the United States Department of Health and Human Services.

(7) A health insurer shall authorize and permit assignment of the insured's right, if any, to any reimbursement for health care services covered under the health insurance policy to a noncontracting individual health professional who furnishes the health care services rendered subject to Section 10112.8. Lack of assignment pursuant to this paragraph shall not be construed to limit the applicability of this section, Section 10112.8, or Section 10112.81.

(8) A noncontracting individual health professional or health insurer who disputes the claim reimbursement under this section shall utilize the independent dispute resolution process described in Section 10112.81.

(b) If nonemergency services are provided by a noncontracting individual health professional consistent with subdivision (c) of Section 10112.8 to an insured who has voluntarily chosen to use the insured's out-of-network benefit for services covered by an insurer that includes coverage for out-of-network benefits, unless otherwise agreed to by the insurer and the noncontracting individual health professional, the amount paid by the insurer shall be the amount set forth in the insured's policy. This payment is not subject to the independent dispute resolution process described in Section 10112.81.

(c) If a health insurer delegates the responsibility for payment of claims to a contracted entity, including, but not limited to, a medical group or independent practice association, then the entity to which that responsibility is delegated shall comply with the requirements of this section.

(d) (1) A payment made by the health insurer to the noncontracting health care professional for nonemergency services as required by Section 10112.8 and this section, in addition to the applicable cost sharing owed by the insured, shall constitute payment in full for nonemergency services rendered unless either party uses the dispute resolution process or other lawful means pursuant to Section 10112.81.

(2) Notwithstanding any other law, the amounts paid by an insurer for services under this section shall not constitute the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an individual health professional.

(3) This subdivision shall not preclude the use of the independent dispute resolution process pursuant to Section 10112.81.

(e) This section shall not apply to emergency services and care, as defined in Section 1317.1 of the Health and Safety Code.

(f) The definitions in subdivision (f) of Section 10112.8 shall apply for purposes of this section.

(g) This section shall not be construed to alter a health insurer's obligations pursuant to Section 10123.13.

(Amended by Stats. 2021, Ch. 615, Sec. 308. (AB 474) Effective January 1, 2022. Operative January 1, 2023, pursuant to Sec. 463 of Stats. 2021, Ch. 615.)

10112.9. (a) (1) Notwithstanding Section 10273.4, an insurer, except an insurer issuing a specialized health insurance policy, issuing a policy or certificate of health insurance, as defined in subdivision (b) of Section 106, shall not market, offer, amend, issue, or renew a large group plan contract that provides a minimum value of less than 60 percent.

(2) This section shall not apply to limited wraparound coverage, that is consistent with Section 146.145(b) of Title 45 of the Code of Federal Regulations. This section also shall not apply to a policy that provides coverage of Medicare services pursuant to contracts with the United States government.

(3) This section shall not apply to a grandfathered health insurance policy that provides basic health care services, as defined in subdivision (b) of Section 1345 of the Health and Safety Code, without annual or lifetime limits for any of the basic health care services.

(b) For purposes of this section, a plan shall provide a minimum value of at least 60 percent, as described in Section 36B(c)(2)(C) of the federal Internal Revenue Code and any regulations or guidance adopted under that section.

(c) This section shall not apply to an insurer that is subject to the disclosure requirements described in Section 10198.61.

(d) For purposes of this section, the following definitions apply:

(1) “Large group” means a group that is not a “small employer,” as defined in Section 10753.

(2) “Plan year” has the meaning set forth in Section 144.103 of Title 45 of the Code of Federal Regulations.

(Added by Stats. 2015, Ch. 617, Sec. 3. (AB 248) Effective January 1, 2016.)

10112.95. (a) A health insurer shall provide an insured who has been displaced or whose health otherwise may be affected by a state of emergency, as declared by the Governor pursuant to Section 8625 of the Government Code, or a health emergency, as declared by the State Public Health Officer pursuant to Section 101080 of the Health and Safety Code, access to medically necessary health care services.

(b) Within 48 hours of a declaration by the Governor of a state of emergency or a declaration by the State Public Health Officer of a health emergency that displaces, or has the immediate potential to displace, insureds or health care providers, or that otherwise affects, or may affect, health care providers or the health of insureds, a health insurer operating in the county or counties included in the declaration shall file with the department a notification describing whether the insurer has experienced or expects to experience any disruption to the operation of the insurer, explaining how the insurer is communicating with potentially impacted insureds, and summarizing the actions the insurer has taken or is in the process of taking to ensure that the health care needs of insureds are met. The department may require the insurer to take actions, including, but not limited to, the following:

(1) Shorten time limits for health insurers to approve prior authorization, precertification, or referrals, and extend the time that prior authorizations, precertifications, and referrals remain valid.

(2) Extend filing deadlines for claims.

(3) Suspend prescription refill limitations and allow an impacted insured to refill their prescriptions at an out-of-network pharmacy.

(4) Authorize an insured to replace medical equipment or supplies.

(5) Allow an insured to access an appropriate out-of-network provider if an in-network provider is unavailable due to the state of emergency or if the insured is out of the area due to displacement.

(6) Have a toll-free telephone number that an affected insured may call for answers to questions, including questions about the loss of health insurance identification cards, access to prescription refills, or how to access health care.

(c) This section shall not be construed to limit the Governor’s authority under the California Emergency Services Act (Chapter 7 (commencing with Section 8550) of Division 1 of Title 2 of the Government Code), or the commissioner’s authority under any provision of this part.

(d) The commissioner may issue guidance to insurers regarding compliance with this section during the first three years following the declaration of emergency, or until the emergency is terminated, whichever occurs first. This guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(Amended by Stats. 2022, Ch. 421, Sec. 2. (SB 979) Effective January 1, 2023.)

10113. Every policy of life, disability, or life and disability insurance issued or delivered within this State on or after the first day of January, 1936, by any insurer doing such business within this State shall contain and be deemed to constitute the entire contract between the parties and nothing shall be incorporated therein by reference to any constitution, by-laws, rules, application or other writings, of either of the parties thereto or of any other person, unless the same are indorsed upon or attached to the policy; and all statements purporting to be made by the insured shall, in the absence of fraud, be representations and not warranties. Any waiver of the provisions of this section shall be void.

(Added by Stats. 1935, Ch. 245.)

10113.1. The following provisions shall apply to this act:

(a) “Advertisement” means any written, electronic, or printed communication or any communication by means of recorded telephone messages or transmitted on radio, television, the Internet, or similar communications media, including film strips, motion pictures, and videos, published, disseminated, circulated, or placed before the public, directly or indirectly, for the purpose of creating an interest in or inducing a person to purchase or sell, assign, devise, bequest, or transfer the death benefit or ownership of a life insurance policy or an interest in a life insurance policy pursuant to a life settlement contract.

(b) “Broker” means a person who, on behalf of an owner, and for a fee, commission, or other valuable consideration, offers or attempts to negotiate life settlement contracts between an owner and providers. A broker represents only the owner and owes a fiduciary duty to the owner to act according to the owner’s instructions, and in the best interest of the owner, notwithstanding the manner in which the broker is compensated. A broker does not include an attorney, certified public accountant, or financial planner retained in the type of practice customarily performed in his or her professional capacity to represent the owner whose compensation is not paid directly or indirectly by the provider or any other person, except the owner.

(c) “Business of life settlements” means an activity involved in, but not limited to, offering to enter into, soliciting, negotiating, procuring, effectuating, monitoring, or tracking of life settlement contracts.

(d) “Commissioner” means the Insurance Commissioner.

(e) “Financing entity” means an underwriter, placement agent, lender, purchaser of securities, purchaser of a policy or certificate from a provider, credit enhancer, or any entity that has a direct ownership in a policy or certificate that is the subject of a life settlement contract, as to which both of the following apply:

(1) It is an entity whose principal activity related to the transaction is providing funds to effect the life settlement contract or purchase of one or more policies.

(2) It is an entity that has an agreement in writing with one or more providers to finance the acquisition of life settlement contracts.

(f) “Financing transaction” means a transaction in which a licensed provider obtains financing from a financing entity, including, without limitation, any secured or unsecured financing, any securitization transaction, or any securities offering which either is registered or exempt from registration under federal and state securities law.

(g) “Fraudulent life settlement act” includes all of the following:

(1) Acts or omissions committed by any person that, for the purpose of depriving another of property or for pecuniary gain, commits or permits its employees or its agents to engage in acts, including, but not limited to, the following:

(A) Presenting, causing to be presented, or preparing with knowledge and belief that it will be presented to or by a provider, premium finance lender, broker, insurer, insurance producer, or any other person, false material information, or concealing material information, as part of, in support of, or concerning a fact material to one or more of the following:

(i) An application for the issuance of a life settlement contract or insurance policy.

(ii) The underwriting of a life settlement contract or insurance policy.

(iii) A claim for payment or benefit pursuant to a life settlement contract or insurance policy.

(iv) Premiums paid on an insurance policy.

(v) Payments and changes in ownership or beneficiary made in accordance with the terms of a life settlement contract or insurance policy.

(vi) The reinstatement or conversion of an insurance policy.

(vii) The solicitation, offer to enter into, or effectuation of, a life settlement contract or insurance policy.

(viii) The issuance of written evidence of life settlement contracts or insurance.

(ix) Any application for, or the existence of or any payments related to, a loan secured directly or indirectly by any interest in a life insurance policy.

(B) Entering into stranger-originated life insurance (STOLI).

(C) Employing any device, scheme, or artifice to defraud in the business of life settlements.

(2) Any of the following that any person does, or permits his or her employees or agents to do, in the furtherance of a fraud, or to prevent the detection of a fraud:

(A) Remove, conceal, alter, destroy, or sequester from the commissioner the assets or records of a licensee or other person engaged in the business of life settlements.

(B) Misrepresent or conceal the financial condition of a licensee, financing entity, insurer, or other person.

(C) Transact the business of life settlements in violation of laws requiring a license, certificate of authority, or other legal authority for the transaction of the business of life settlements.

(D) File with the commissioner or the chief insurance regulatory official of another jurisdiction a document containing false information or otherwise concealing information about a material fact from the commissioner.

(E) Engage in embezzlement, theft, misappropriation, or conversion of moneys, funds, premiums, credits, or other property of a provider, insurer, insured, owner, insurance policyowner, or any other person engaged in the business of life settlements or insurance.

(F) Enter into, broker, or otherwise deal in a life settlement contract, the subject of which is a life insurance policy that was obtained by presenting false information concerning any fact material to the policy or by concealing, for the purpose of misleading another, information requested concerning any fact material to the policy, where the owner or the owner's agent intended to defraud the policy's issuer.

(G) Attempt to commit, assist, aid, or abet in the commission of, or conspiracy to commit the acts or omissions specified in this subdivision.

(H) Misrepresent the state of residence of an owner to be a state or jurisdiction that does not have a law substantially similar to this act for the purpose of evading or avoiding the provisions of this act.

(h) "Insured" means the person covered under the policy being considered for sale in a life settlement contract.

(i) "Life expectancy" means the arithmetic mean of the number of months the insured under the life insurance policy to be settled can be expected to live considering medical records and appropriate experiential data.

(j) "Life insurance producer" means any person licensed in this state as a resident or nonresident insurance agent who has received qualification or authority for life insurance coverage or a life line of coverage pursuant to Chapter 5 (commencing with Section 1621) of Part 2 of Division 1.

(k) "Life settlement contract" means a written agreement solicited, negotiated, or entered into in this state between a provider and an owner, establishing the terms under which compensation or any thing of value will be paid, which compensation or thing of value is less than the expected death benefit of the insurance policy or certificate, in return for the owner's assignment, transfer, sale, devise, or bequest of the death benefit or any portion of an insurance policy or certificate of insurance for compensation, provided, however, that the minimum value for a life settlement contract shall be greater than a cash surrender value or accelerated death benefit available at the time of an application for a life settlement contract. "Life settlement contract" also includes the transfer for compensation or value of ownership or beneficial interest in a trust or other entity that owns such policy if the trust or other entity was formed or availed of for the principal purpose of acquiring one or more life insurance contracts, which life insurance contract is owned by a person residing in this state.

(1) A "life settlement contract" includes a premium finance loan made for a policy on or before the date of issuance of the policy where one or more of the following conditions apply:

(A) The loan proceeds are not used solely to pay premiums for the policy and any costs or expenses incurred by the lender or the borrower in connection with the financing.

(B) The owner receives on the date of the premium finance loan a guarantee of the future life settlement value of the policy.

(C) The owner agrees on the date of the premium finance loan to sell the policy or any portion of the policy's death benefit on any date following the issuance of the policy, not including an agreement to sell the policy in the event of a default, provided that the default is not pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this act.

(2) "Life settlement contract" does not include any of the following:

(A) A policy loan by a life insurance company pursuant to the terms of the life insurance policy or accelerated death provisions contained in the life insurance policy, whether issued with the original policy or as a rider.

(B) A premium finance loan, as defined herein, or any loan made by a bank or other licensed financial institution, provided that neither default on the loan nor the transfer of the policy in connection with the default is pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this act.

(C) A collateral assignment of a life insurance policy by an owner.

(D) A loan made by a lender that does not violate Article 5.8 (commencing with Section 778) of Chapter 1 of Part 2, provided the loan is not described in paragraph (1), and is not otherwise within the definition of life settlement contract.

(E) An agreement where all of the parties satisfy one of the following conditions:

(i) They are closely related to the insured by blood or law.

(ii) They have a lawful substantial economic interest in the continued life, health, and bodily safety of the person insured.

(iii) They are trusts established primarily for the benefit of those parties.

(F) Any designation, consent, or agreement by an insured who is an employee of an employer in connection with the purchase by the employer, or by a trust established by the employer of life insurance on the life of the employee.

(G) A bona fide business succession planning arrangement:

(i) Between one or more shareholders in a corporation or between a corporation and one or more of its shareholders or one or more trusts established by its shareholders.

(ii) Between one or more partners in a partnership or between a partnership and one or more of its partners or one or more trusts established by its partners.

(iii) Between one or more members in a limited liability company or between a limited liability company and one or more of its members or one or more trusts established by its members.

(H) An agreement entered into by a service recipient, or a trust established by the service recipient, and a service provider, or a trust established by the service provider, who performs significant services for the service recipient's trade or business.

(I) Any other contract, transaction, or arrangement from the definition of "life settlement contract" that the commissioner determines is not of the type intended to be regulated by this act.

(l) "Net death benefit" means the amount of the life insurance policy or certificate to be settled less any outstanding debts or liens.

(m) "Owner" means the owner of a life insurance policy or a certificate holder under a group policy, with or without a terminal illness, who enters or seeks to enter into a life settlement contract. For the purposes of this article, an owner shall not be limited to an owner of a life insurance policy or a certificate holder under a group policy that insures the life of an individual with a terminal illness or condition except where specifically addressed. The term "owner" does not include any of the following:

(1) Any provider or other licensee under this act.

(2) A qualified institutional buyer as defined in Rule 144A of the federal Securities Act of 1933, as amended.

(3) A financing entity.

(4) A special purpose entity.

(5) A related provider trust.

(n) "Patient identifying information" means an insured's address, telephone number, facsimile number, electronic mail address, photograph or likeness, employer, employment status, social security number, or any other information that is likely to lead to the identification of the insured.

(o) “Person” means any natural person or legal entity, including, but not limited to, a partnership, limited liability company, association, trust, or corporation.

(p) “Policy” means an individual or group policy, group certificate, contract, or arrangement of life insurance owned by a resident of this state, regardless of whether delivered or issued for delivery in this state.

(q) “Premium finance loan” is a loan made primarily for the purpose of making premium payments on a life insurance policy, which loan is secured by an interest in such life insurance policy.

(r) “Provider” means a person, other than an owner, who enters into or effectuates a life settlement contract with an owner. A provider does not include any of the following:

(1) Any bank, savings bank, savings and loan association, or credit union.

(2) A licensed lending institution or creditor or secured party pursuant to a premium finance loan agreement which takes an assignment of a life insurance policy or certificate issued pursuant to a group life insurance policy as collateral for a loan.

(3) The insurer of a life insurance policy or rider to the extent of providing accelerated death benefits or riders or cash surrender value.

(4) A purchaser.

(5) Any authorized or eligible insurer that provides stop loss coverage to a provider, purchaser, financing entity, special purpose entity, or related provider trust.

(6) A financing entity.

(7) A related provider trust.

(8) A broker.

(9) An accredited investor or qualified institutional buyer as defined respectively in Regulation D, Rule 501 or Rule 144A of the federal Securities Act of 1933, as amended, who purchases a life settlement policy from a provider.

(s) “Purchaser” means a person who pays compensation or anything of value as consideration for a beneficial interest in a trust which is vested with, or for the assignment, transfer, or sale of, an ownership or other interest in a life insurance policy or a certificate issued pursuant to a group life insurance policy which has been the subject of a life settlement contract.

(t) “Related provider trust” means a titling trust or other trust established by a licensed provider or a financing entity for the sole purpose of holding the ownership or beneficial interest in purchased policies in connection with a financing transaction. In order to qualify as a related provider trust, the trust must have a written agreement with the licensed provider under which the licensed provider is responsible for ensuring compliance with all statutory and regulatory requirements and under which the trust agrees to make all records and files relating to life settlement transactions available to the Department of Insurance as if those records and files were maintained directly by the licensed provider.

(u) “Settled policy” means a life insurance policy or certificate that has been acquired by a provider pursuant to a life settlement contract.

(v) “Special purpose entity” means a corporation, partnership, trust, limited liability company, or other legal entity whose securities pay a fixed rate of return commensurate with established asset-backed capital markets, or has been formed solely to provide either directly or indirectly access to institutional capital markets:

(1) For a financing entity or provider.

(2) In connection with a transaction in which the securities in the special purpose entity are acquired by the owner or by a “qualified institutional buyer” as defined in Rule 144 promulgated under the federal Securities Act of 1933, as amended.

(w) “Stranger-originated life insurance” or “STOLI” is an act, practice, or arrangement to initiate the issuance of a life insurance policy in this state for the benefit of a third-party investor who, at the time of policy origination, has no insurable interest, under the laws of this state, in the life of the insured. STOLI practices include, but are not limited to, cases in which life insurance is purchased with resources or guarantees from or through a person or entity, that, at the time of policy inception, could not lawfully initiate the policy himself, herself, or itself, and where, at the time of inception, there is an arrangement or agreement, to directly or indirectly transfer the ownership of the policy or the policy benefits to a third party. Trusts that are created to give the appearance of insurable interest and that are used to initiate policies for investors violate insurable interest laws and the prohibition against wagering on life. STOLI arrangements do not include lawful life settlement contracts as permitted by the act that added this section or those practices set forth in paragraph (2) of subdivision (k), provided that they are not for the purpose of evading regulation under this act.

(x) “Terminally ill” means having an illness or sickness that can reasonably be expected to result in death in 24 months or less.

(y) “This act” shall refer to the act in the 2009–10 Regular Session that added Sections 10113.1 to 10113.35, inclusive, and as it may from time to time be amended.

(Repealed and added by Stats. 2009, Ch. 343, Sec. 3. (SB 98) Effective January 1, 2010.)

10113.2. (a) This section applies to any person entering into, brokering, or soliciting life settlements pursuant to this section and Sections 10113.1 and 10113.3.

(b) (1) Except as provided in subparagraph (B) or (D), a person may not enter into, broker, or solicit life settlements pursuant to Section 10113.1 unless that person has been licensed by the commissioner under this section. The person shall file an application for a license in the form prescribed by the commissioner, and the application shall be accompanied by a fee of one hundred seventy-one dollars ($171). The annual license renewal fee shall be one hundred seventy-one dollars ($171). The applicant shall provide any information the commissioner may require. The commissioner may issue a license, or deny the application if, in the commissioner’s discretion, it is determined that it is contrary to the interests of the public to issue a license to the applicant. The reasons for a denial shall be set forth in writing.

(A) An individual acting as a broker under this section shall complete at least 15 hours of continuing education related to life settlements and life settlement transactions, as required and approved by the commissioner, prior to operating as a broker. This requirement shall not apply to a life insurance producer who qualifies under subparagraph (D).

(B) A person licensed as an attorney, certified public accountant, or financial planner accredited by a nationally recognized accreditation agency, who is retained to represent the owner, and whose compensation is not paid directly or indirectly by the provider or purchaser, may negotiate a life settlement contract on behalf of the owner without having to obtain a license as a broker.

(C) A person licensed to act as a viatical settlement broker or provider as of December 31, 2009, shall be deemed qualified for licensure as a life settlement broker or provider, and shall be subject to all the provisions of this article as if the person were originally licensed as a life settlement broker or provider.

(D) (i) A life insurance producer who has been duly licensed as a life agent for at least one year or as a licensed nonresident producer in this state for one year shall be deemed to meet the licensing requirements of this section and shall be permitted to operate as a broker.

(ii) Not later than 10 days from the first day of operating as a broker, the life insurance producer shall notify the commissioner that the life insurance producer is acting as a broker, on a form prescribed by the commissioner, and shall pay a fee of eighty-five dollars ($85).

(iii) The fee shall be paid by the life insurance producer for each license term the producer intends to operate as a broker. The fee shall be calculated pursuant to Section 1750. The notification to the commissioner shall include an acknowledgment by the life insurance producer that the life insurance producer will operate as a broker in accordance with this act.

(iv) The insurer that issued the policy that is the subject of a life settlement contract shall not be responsible for any act or omission of a broker or provider arising out of, or in connection with, the life settlement transaction, unless the insurer receives compensation for the replacement of the life settlement contract for the provider or broker.

(E) The commissioner shall review the examination for the licensing of life insurance agents and may recommend any changes to the examination to the department’s curriculum committee in order to carry out the purposes of this section and Sections 10113.1 and 10113.3.

(2) Except as provided in subparagraphs (A) and (B), whenever it appears to the commissioner that it is contrary to the interests of the public for a person licensed pursuant to this section to continue to transact life settlements business, the commissioner or their designee shall issue a notice to the licensee stating the reasons therefor. If, after a hearing, the commissioner concludes that it is contrary to the interests of the public for the licensee to continue to transact life settlements business, the commissioner may revoke the person’s license, or issue an order suspending the license for a period as determined by the commissioner. Any hearing conducted pursuant to this paragraph shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that the hearing may be conducted by administrative law judges chosen pursuant to Section 11502 or appointed by the commissioner, and the commissioner shall have the powers granted therein.

(A) The commissioner may, without hearing, suspend or revoke the license of a broker, as defined in subdivision (b) of Section 10113.1, if the broker has done one or more of the following:

(i) Been convicted of a felony.

(ii) Been convicted of a misdemeanor specified by this code or by other laws regulating insurance.

(iii) Had a previously issued professional, occupational, or vocational license suspended or revoked for cause by a licensing authority within the preceding five years of the commissioner's action on grounds that would preclude the granting of a license by the commissioner under this section.

(B) A judgment, plea, or verdict of guilty, or a plea of nolo contendere is deemed to be a conviction within the meaning of subparagraph (A). If the commissioner issues an order based on a plea that does not at any time result in a judgment of conviction, the commissioner shall vacate the order upon petition by the broker.

(3) Each licensee shall owe and pay in advance to the commissioner an annual renewal fee in an amount to be determined by the commissioner pursuant to paragraph (1) of subdivision (b). This fee shall be for each license year, as defined by Section 1629.

(4) Any licensee that intends to discontinue transacting life settlements in this state shall so notify the commissioner, and shall surrender its license.

(c) A life settlements licensee shall file with the department a copy of all life settlement forms used in this state. A licensee may not use any life settlement form in this state unless it has been provided in advance to the commissioner. The commissioner may disapprove a life settlement form if, in the commissioner's discretion, the form, or provisions contained therein, are contrary to the interests of the public, or otherwise misleading or unfair to the consumer. In the case of disapproval, the licensee may, within 15 days of notice of the disapproval, request a hearing before the commissioner or the commissioner's designee, and the hearing shall be held within 30 days of the request.

(d) Life settlements licensees shall be required to provide any applicant for a life settlement contract, at the time of application for the life settlement contract, all of the following disclosures in writing and signed by the owner, in at least 12-point type:

(1) That there are possible alternatives to life settlements, including, but not limited to, accelerated benefits options that may be offered by the life insurer.

(2) The fact that some or all of the proceeds of a life settlement may be taxable and that assistance should be sought from a professional tax adviser.

(3) Consequences for interruption of public assistance as provided by information provided by the State Department of Health Care Services and the State Department of Social Services under Section 11022 of the Welfare and Institutions Code.

(4) That the proceeds from a life settlement could be subject to the claims of creditors.

(5) That entering into a life settlement contract may cause other rights or benefits, including conversion rights and waiver of premium benefits that may exist under the policy or certificate of a group policy to be forfeited by the owner and that assistance should be sought from a professional financial adviser.

(6) That a change in ownership of the settled policy could limit the insured's ability to purchase insurance in the future on the insured's life because there is a limit to how much coverage insurers will issue on one life.

(7) That the owner has a right to rescind a life settlement contract within 30 days of the date it is executed by all parties and the owner has received all required disclosures, or 15 days from receipt by the owner of the proceeds of the settlement, whichever is sooner. Rescission, if exercised by the owner, is effective only if both notice of rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider.

(8) That proceeds will be sent to the owner within three business days after the provider has received the insurer or group administrator's acknowledgment that ownership of the policy or the interest in the certificate has been transferred and the beneficiary has been designated in accordance with the terms of the life settlement contract.

(9) The date by which the funds will be available to the owner and the transmitter of the funds.

(10) The disclosure document shall include the following language:

"All medical, financial, or personal information solicited or obtained by a provider or broker about an insured, including the insured's identity or the identity of family members, a spouse, or a significant other may be disclosed as necessary to effect the life settlement contract between the owner and provider. If you are asked to provide this information, you will be asked to consent to the disclosure.

The information may be provided to someone who buys the policy or provides funds for the purchase. You may be asked to renew your permission to share information every two years."

(11) That the insured may be contacted by either the provider or the broker or its authorized representative for the purpose of determining the insured's health status or to verify the insured's address. This contact is limited to once every three months if the insured has a life expectancy of more than one year, and no more than once per month if the insured has a life expectancy of one year or less.

(12) Any affiliations or contractual relations between the provider and the broker, and the affiliation, if any, between the provider and the issuer of the policy to be settled.

(13) That a broker represents exclusively the owner, and not the insurer or the provider or any other person, and owes a fiduciary duty to the owner, including a duty to act according to the owner's instructions and in the best interest of the owner.

(14) The name, business address, and telephone number of the broker.

(e) Prior to the execution of the life settlement contract by all parties, the life settlement provider entering into a life settlement contract with the owner shall provide, in a document signed by the owner, the gross purchase price the life settlement provider is paying for the policy, the amount of the purchase price to be paid to the owner, the amount of the purchase price to be paid to the owner's life settlement broker, and the name, business address, and telephone number of the life settlement broker. For purposes of this section, "gross purchase price" means the total amount or value paid by the provider for the purchase of one or more life insurance policies, including commissions and fees.

(f) The broker shall provide the owner and the insured with at least all of the following disclosures in writing prior to the signing of the life settlement contract by all parties. The disclosures shall be clearly displayed in the life settlement contract or in a separate document signed by the owner:

(1) The name, business address, and telephone number of the broker.

(2) A full, complete, and accurate description of all of the offers, counteroffers, acceptances, and rejections relating to the proposed life settlement contract.

(3) A disclosure of any affiliations or contractual arrangements between the broker and any person making an offer in connection with the proposed life settlement contract.

(4) All estimates of the life expectancy of the insured that are obtained by the licensee in connection with the life settlement, unless that disclosure would violate any California or federal privacy laws.

(5) The commissioner may consider any failure to provide the disclosures or rights described in this section as a basis for suspending or revoking a broker's or provider's license pursuant to paragraph (2) of subdivision (b).

(g) All medical information solicited or obtained by any person soliciting or entering into a life settlement is subject to Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2 of Division 1, concerning confidentiality of medical information.

(h) Except as otherwise allowed or required by law, a provider, broker, insurance company, insurance producer, information bureau, rating agency, or company, or any other person with actual knowledge of an insured's identity, shall not disclose the identity of an insured or information that there is a reasonable basis to believe that could be used to identify the insured or the insured's financial or medical information to any other person unless the disclosure is one of the following:

(1) It is necessary to effect a life settlement contract between the owner and a provider and the owner and insured have provided prior written consent to the disclosure.

(2) It is necessary to effectuate the sale of life settlement contracts, or interests therein, as investments, provided the sale is conducted in accordance with applicable state and federal securities law and provided further that the owner and the insured have both provided prior written consent to the disclosure.

(3) It is provided in response to an investigation or examination by the commissioner or any other governmental officer or agency or any other provision of law.

(4) It is a term or condition to the transfer of a policy by one provider to another provider, in which case the receiving provider shall be required to comply with the confidentiality requirements of Article 6.6 (commencing with Section 791) of Chapter 1 of Part 2 of Division 1.

(5) It is necessary to allow the provider or broker or their authorized representatives to make contacts for the purpose of determining health status. For the purposes of this section, the term "authorized representative" shall not include any person who

has or may have any financial interest in the settlement contract other than a provider, licensed broker; further, a provider or broker shall require its authorized representative to agree in writing to adhere to the privacy provisions of this act.

(6) It is required to purchase stop loss coverage.

(i) In addition to other questions an insurance carrier may lawfully pose to a life insurance applicant, insurance carriers may inquire in the application for insurance whether the proposed owner intends to pay premiums with the assistance of financing from a lender that will use the policy as collateral to support the financing.

(1) If the premium finance loan provides funds that can be used for a purpose other than paying for the premiums, costs, and expenses associated with obtaining and maintaining the life insurance policy and loan, the application may be rejected as a prohibited practice under this act.

(2) If the financing does not violate paragraph (1), the existence of premium financing may not be the sole criterion employed by an insurer in a decision whether to reject an application for life insurance. The insurance carrier may make disclosures to the applicant, either on the application or an amendment to the application to be completed no later than the delivery of the policy, including, but not limited to, the following:

“If you have entered into a loan arrangement where the policy is used as collateral, and the policy changes ownership at some point in the future in satisfaction of the loan, the following may be true:

(A) A change of ownership could lead to a stranger owning an interest in the insured’s life.

(B) A change of ownership could in the future limit your ability to purchase insurance on the insured’s life because there is a limit to how much coverage insurers will issue on a life.

(C) You should consult a professional adviser since a change in ownership in satisfaction of the loan may result in tax consequences to the owner, depending on the structure of the loan.”

(3) In addition to the disclosures in paragraph (2), the insurance carrier may require the following certifications from the applicant or the insured:

“(A) I have not entered into any agreement or arrangement under which I have agreed to make a future sale of this life insurance policy.

(B) My loan arrangement for this policy provides funds sufficient to pay for some or all of the premiums, costs, and expenses associated with obtaining and maintaining my life insurance policy, but I have not entered into any agreement by which I am to receive consideration in exchange for procuring this policy.

(C) The borrower has an insurable interest in the insured.”

(j) Life insurers shall provide individual life insurance policyholders with a statement informing them that if they are considering making changes in the status of their policy, they should consult with a licensed insurance or financial adviser. The statement may accompany or be included in notices or mailings otherwise provided to the policyholders.

(k) The commissioner may, whenever the commissioner deems it reasonably necessary to protect the interests of the public, examine the business and affairs of any licensee or applicant for a license. The commissioner shall have the authority to order any licensee or applicant to produce any records, books, files, or other information as is reasonably necessary to ascertain whether or not the licensee or applicant is acting or has acted in violation of the law or otherwise contrary to the interests of the public. The expenses incurred in conducting any examination shall be paid by the licensee or applicant.

(l) The commissioner may investigate the conduct of any licensee, its officers, employees, agents, or any other person involved in the business of the licensee, or any applicant for a license, whenever the commissioner has reason to believe that the licensee or applicant for a license may have acted, or may be acting, in violation of the law, or otherwise contrary to the interests of the public. The commissioner may initiate an investigation on the commissioner’s own initiative, or upon a complaint filed by any other person.

(m) The commissioner may issue orders to licensees whenever the commissioner determines that it is reasonably necessary to ensure or obtain compliance with this section, or Section 10113.3. This authority includes, but is not limited to, orders directing a licensee to cease and desist in any practice that is in violation of this section, or Section 10113.3, or otherwise contrary to the interests of the public. Any licensee to which an order pursuant to this subdivision is issued may, within 15 days of receipt of that order, request a hearing at which the licensee may challenge the order.

(n) The commissioner may, after notice and a hearing at which it is determined that a licensee has violated this section or Section 10113.3 or any order issued pursuant to this section, order the licensee to pay a monetary penalty of up to ten thousand dollars

($10,000), which may be recovered in a civil action. Any hearing conducted pursuant to this subdivision shall be in accordance with Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, except that the hearing may be conducted by administrative law judges chosen pursuant to Section 11502 or appointed by the commissioner, and the commissioner shall have the powers granted therein.

(o) Each licensed provider shall file with the commissioner on or before March 1 of each year an annual statement in the form prescribed by the commissioner. The information that the commissioner may require in the annual statement shall include, but not be limited to, the total number, aggregate face amount, and life settlement proceeds of policies settled during the immediately preceding calendar year, together with a breakdown of the information by policy issue year. The annual statement shall also include the names of the insurance companies whose policies have been settled and the brokers that have settled those policies, and that information shall be received in confidence within the meaning of Section 7929.000 of the Government Code and exempt from disclosure pursuant to the Public Records Act (Division 10 (commencing with Section 7920.000) of Title 1 of the Government Code). The annual statement shall not include individual transaction data regarding the business of life settlements or information that there is a reasonable basis to believe could be used to identify the owner or the insured.

(p) A person who is not a resident of California may not receive or maintain a license unless a written designation of an agent for service of process is filed and maintained with the commissioner. The provisions of Article 3 (commencing with Section 1600) of Chapter 4 of Part 2 of Division 1 shall apply to life settlements licensees as if they were foreign insurers, their license a certificate of authority, and the life settlements a policy, and the commissioner may modify the agreement set forth in Section 1604 accordingly.

(q) A person licensed pursuant to this section shall not engage in any false or misleading advertising, solicitation, or practice. In no case shall a broker or provider, directly or indirectly, market, advertise, solicit, or otherwise promote the purchase of a new policy for the sole purpose of or with a primary emphasis on settling the policy or use the words “free,” “no cost,” or words of similar import in the marketing, advertising, soliciting, or otherwise promoting of the purchase of a policy. The provisions of Article 6 (commencing with Section 780) and Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1 shall apply to life settlements licensees as if they were insurers, their license a certificate of authority or producer’s license, and the life settlements a policy, and the commissioner shall liberally construe these provisions so as to protect the interests of the public.

(r) Any person who enters into a life settlement with a life settlements licensee shall have the absolute right to rescind the settlement within 30 days of the date it is executed by all parties and the owner has received all required disclosures, or 15 days from receipt by the owner of the proceeds of the settlement, whichever is sooner, and any waiver or settlement language contrary to this subdivision shall be void. Rescission, if exercised by the owner, is effective only if both notice of rescission is given and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner’s estate of all proceeds and any premiums, loans, and loan interest to the provider.

(s) Records of all consummated transactions and life settlement contracts shall be maintained by the provider for three years after the death of the insured and shall be available to the commissioner for inspection during reasonable business hours.

(t) A violation of this section is a misdemeanor.

(Amended by Stats. 2023, Ch. 204, Sec. 14. (AB 1140) Effective January 1, 2024.)

10113.3. (a) A provider entering into a life settlement contract with any owner of a policy, wherein the insured is terminally ill, shall first obtain the following:

(1) If the owner is the insured, a written statement from a licensed attending physician that the owner is of sound mind and under no constraint or undue influence to enter into a settlement contract.

(2) A document in which the insured consents to the release of his or her medical records to a provider, settlement broker, or insurance producer and, if the policy was issued less than two years from the date of application for a settlement contract, to the insurance company that issued the policy.

(b) The insurer shall respond to a request for verification of coverage submitted by a provider, settlement broker, or life insurance producer not later than 30 calendar days of the date the request is received. The request for verification of coverage must be made on a form approved by the commissioner. The insurer shall complete and issue the verification of coverage or indicate in which respects it is unable to respond. In its response, the insurer shall indicate whether, based on the medical evidence and documents provided, the insurer intends to pursue an investigation at this time regarding the validity of the insurance contract.

(c) Before or at the time of execution of the settlement contract, the provider shall obtain a witnessed document in which the owner consents to the settlement contract, represents that the owner has a full and complete understanding of the settlement contract and a full and complete understanding of the benefits of the policy, acknowledges that the owner is entering into the settlement contract freely and voluntarily, and, for persons with a terminal illness or condition, acknowledges that the insured has a terminal illness and that the terminal illness or condition was diagnosed after the policy was issued.

(d) The insurer shall not unreasonably delay effecting change of ownership or beneficiary with any life settlement contract lawfully entered into in this state or with a resident of this state.

(e) If a settlement broker or life insurance producer performs any of these activities required of the provider, the provider is deemed to have fulfilled the requirements of this section.

(f) If a broker performs those verification of coverage activities required of the provider, the provider is deemed to have fulfilled the requirements of this section.

(g) Within 20 days after an owner executes the life settlement contract, the provider shall give written notice to the insurer that issued that insurance policy that the policy has become subject to a life settlement contract. The notice shall be accompanied by the documents required by subdivision (d) of Section 10113.2.

(h) All medical information solicited or obtained by any licensee shall be subject to the applicable provision of state law relating to confidentiality of medical information, if not otherwise provided in this act.

(i) All life settlement contracts entered into in this state shall provide that the owner may rescind the contract on or before 30 days after the date it is executed by all parties thereto, and the owner has received all required disclosures, or 15 days from receipt by the owner of the full payment of the proceeds as specified below, whichever is sooner. Rescission, if exercised by the owner, is effective only if both notice of the rescission is given, and the owner repays all proceeds and any premiums, loans, and loan interest paid on account of the provider within the rescission period. If the insured dies during the rescission period, the contract shall be deemed to have been rescinded subject to repayment by the owner or the owner's estate of all proceeds and any premiums, loans, and loan interest to the provider.

(j) Within three business days after receipt from the owner of documents to effect the transfer of the insurance policy, the provider shall pay the proceeds of the settlement to an escrow or trust account managed by a trustee or escrow agent in a state or federally chartered financial institution pending acknowledgment of the transfer by the issuer of the policy. The trustee or escrow agent shall be required to transfer the proceeds due to the owner within three business days of acknowledgment of the transfer from the insurer.

(k) Failure to tender the life settlement contract proceeds to the owner by the date disclosed to the owner renders the contract voidable by the owner for lack of consideration until the time the proceeds are tendered to and accepted by the owner. A failure to give written notice of the right of rescission hereunder shall toll the right of rescission until 30 days after the written notice of the right of rescission has been given.

(l) Any fee paid by a provider, party, individual, or an owner to a broker in exchange for services provided to the owner pertaining to a life settlement contract shall be computed as a percentage of the offer obtained, not the face value of the policy. Nothing in this section shall be construed as prohibiting a broker from reducing the broker's fee below this percentage if the broker so chooses.

(m) No person at any time prior to, or at the time of, the application for, or issuance of, a policy, or during a two-year period commencing with the date of issuance of the policy, shall enter into a life settlement regardless of the date the compensation is to be provided and regardless of the date the assignment, transfer, sale, devise, bequest, or surrender of the policy is to occur.

(1) This prohibition shall not apply if the owner certifies to the provider that the policy was issued upon the owner's exercise of conversion rights arising out of a group or individual policy, provided the total of the time covered under the conversion policy plus the time covered under the prior policy is at least 24 months. The time covered under a group policy must be calculated without regard to a change in insurance carriers, provided the coverage has been continuous and under the same group sponsorship.

(2) This prohibition shall not apply if the owner submits independent evidence to the provider that one or more of the following conditions have been met within the two-year period:

(A) The owner or insured is terminally ill.

(B) The owner or insured disposes of his or her ownership interests in a closely held corporation, pursuant to the terms of a buyout or other similar agreement in effect at the time the insurance policy was initially issued.

(C) The owner's spouse dies.

(D) The owner divorces his or her spouse.

(E) The owner retires from full-time employment.

(F) The owner becomes physically or mentally disabled and a physician determines that the disability prevents the owner from maintaining full-time employment.

(G) A final order, judgment, or decree is entered by a court of competent jurisdiction, on the application of a creditor of the owner, adjudicating the owner bankrupt or insolvent, or approving a petition seeking reorganization of the owner or appointing a receiver, trustee, or liquidator to all or a substantial part of the owner's assets.

(3) (A) Copies of the independent evidence required by paragraph (2) shall be submitted to the insurer when the provider submits a request to the insurer for verification of coverage. The copies shall be accompanied by a letter of attestation from the provider that the copies are true and correct copies of the documents received by the provider. Nothing in this section shall prohibit an insurer from exercising its right to contest the validity of any policy.

(B) If the provider submits to the insurer a copy of independent evidence provided for in subparagraph (A) of paragraph (2) when the provider submits a request to the insurer to effect the transfer of the policy to the provider, the copy shall be deemed to establish that the settlement contract satisfies the requirements of this section.

(4) This prohibition shall apply only to policies issued on or after the effective date of this section.

(n) An insurer shall not:

(1) Engage in any transaction, act, or practice that restricts, limits, or impairs the lawful transfer of ownership, change of beneficiary, or assignment of a policy.

(2) Make any false or misleading statement for the purpose of dissuading an owner or insured from a lawful life settlement contract.

(o) No person providing premium financing shall receive any proceeds, fees, or other consideration from the policy or owner of the policy that are in addition to the amounts required to pay principal, interest, and any reasonable costs or expenses incurred by the lender or borrower in connection with the premium finance agreement, except for the event of a default, unless either the default on the loan or transfer of the policy occurs pursuant to an agreement or understanding with any other person for the purpose of evading regulation under this act.

(p) If there is more than one owner on a single policy, and the owners are residents of different states, the life settlement contract shall be governed by the law of the state in which the owner having the largest percentage ownership resides or, if the owners hold equal ownership, the state of residence of one owner agreed upon in writing by all of the owners. The law of the state of the insured shall govern in the event that equal owners fail to agree in writing upon a state of residence for jurisdictional purposes.

(q) A provider from this state who enters into a life settlement contract with an owner who is a resident of another state that has enacted statutes or adopted regulations governing life settlement contracts shall be governed in the effectuation of that life settlement contract by the statutes and regulations of the owner’s state of residence. If the state in which the owner is a resident has not enacted statutes or regulations governing life settlement contracts, the provider shall give the owner notice that neither state regulates the transaction upon which he or she is entering. For transactions in those states, however, the provider is to maintain all records required if the transactions were executed in the state of residence. The forms used in those states need not be approved by the department.

(r) If there is a conflict in the laws that apply to an owner and a purchaser in any individual transaction, the laws of the state that apply to the owner shall take precedence and the provider shall comply with those laws.

(s) It is a fraudulent life settlement act and a violation of this section for any person to do any of the following, or any of the acts listed in subdivision (g) of Section 10113.1:

(1) Enter into a life settlement contract if a person knows or reasonably should have known that the life insurance policy was obtained by means of a false, deceptive, or misleading application for the policy.

(2) Engage in any transaction, practice, or course of business if a person knows or reasonably should have known that the intent was to avoid the notice requirements of this section.

(3) Engage in any fraudulent act or practice in connection with any transaction relating to any settlement involving an owner who is a resident of this state.

(4) Fail to provide the disclosures or file the required reports with the commissioner as required by this act.

(5) Issue, solicit, or market, the purchase of a new life insurance policy for the purpose of, or with a primary emphasis on, settling the policy.

(6) Enter into a premium finance agreement with any person or agency, or any person affiliated with a person or agency that is prohibited under subdivision (o).

(7) With respect to any settlement contract or insurance policy and a broker, knowingly solicit an offer from, effectuate a life settlement contract with, or make a sale to any provider, financing entity, or related provider trust that is controlling, controlled by, or under common control with a broker, unless the relationship has been fully disclosed to the owner.

(8) With respect to any life settlement contract or insurance policy and a provider, knowingly enter into a life settlement contract with an owner, if, in connection with a life settlement contract, anything of value will be paid to a broker that is controlling,

controlled by, or under common control with a provider or the financing entity, or related provider trust that is involved in a settlement contract, unless the relationship has been fully disclosed to the owner.

(9) With respect to a provider, enter into a life settlement contract unless the life settlement promotional, advertising, and marketing materials, as may be prescribed by regulation, have been filed with the commissioner. In no event shall any marketing materials expressly reference that the insurance is “free” for any period of time. The inclusion of any reference in the marketing materials that would cause an owner to reasonably believe that the insurance is free for any period of time shall be considered a violation of this act; or with respect to any life insurance producer, insurance company, broker, or provider make any statement or representation to the applicant or policyholder in connection with the sale or financing of a life insurance policy to the effect that the insurance is free or without cost to the policyholder for any period of time unless provided in the policy.

(t) Life settlement contracts and applications for life settlement contracts, regardless of the form of transmission, shall contain the following statement or a substantially similar statement:

“Any person who knowingly presents false information in an application for insurance or for a life settlement contract may be subject to criminal or civil liability.”

(1) The lack of a statement as required by this subdivision does not constitute a defense in any prosecution for a fraudulent life settlement act.

(2) This act shall not:

(A) Preempt the authority or relieve the duty of other law enforcement or regulatory agencies to investigate, examine, and prosecute suspected violations of law.

(B) Preempt, supersede, or limit any provision of any state securities law or any rule, order, or notice issued thereunder.

(C) Prevent or prohibit a person from disclosing voluntarily information concerning life settlement fraud to a law enforcement or regulatory agency other than the insurance department.

(D) Limit the powers granted elsewhere by the laws of this state to the commissioner or an insurance fraud unit to investigate and examine possible violations of law and to take appropriate action against wrongdoers.

(u) A provider lawfully transacting business in this state prior to the effective date of this act may continue to do so, pending approval or disapproval of that person’s application for a license as long as the application is filed with the commissioner not later than 30 days after publication by the commissioner of an application form and instructions for licensure of providers. If the publication of the application form and instructions is prior to the effective date of this chapter, then the filing of the application shall not be later than 30 days after the effective date of this act. During the time that an application is pending with the commissioner, the applicant may use any form of life settlement contract that has been filed with the commissioner pending approval thereof, provided that the form is otherwise in compliance with the provisions of this act. Any person transacting business in this state under this provision shall be obligated to comply with all other requirements of this act. A person who has lawfully acted as a broker and negotiated life settlement contracts between any owner residing in this state and one or more providers for at least one year immediately prior to the effective date of this act may continue to do so pending approval or disapproval of that person’s application for a license, as long as the application is filed with the commissioner not later than 30 days after publication by the commissioner of an application form and instructions for licensure of brokers. If the publication of the application form and instructions is prior to the effective date of this chapter, then the filing of the application shall not be later than 30 days after the effective date of this act. Any person transacting business in this state under this provision shall be obligated to comply with all other requirements of this act.

(Added by Stats. 2009, Ch. 343, Sec. 6. (SB 98) Effective January 1, 2010.)

10113.35. (a) The commissioner may adopt rules and regulations reasonably necessary to implement the provisions of this act.

(b) This section shall be prospective only, and nothing in the act adding this section shall be interpreted to interfere with or overrule regulations adopted prior to the effective date of this act by the Insurance Commissioner pursuant to the authority granted at the time those regulations were adopted.

(Repealed and added by Stats. 2011, Ch. 414, Sec. 5. (AB 1425) Effective January 1, 2012.)

10113.4. If a group life insurance policy contains a provision that makes a certificate holder’s coverage contestable on the grounds of suicide for a period following commencement of coverage, only the unexpired portion of that period shall be applied to a certificate holder’s individual conversion policy of an equal or lesser amount of coverage.

(Added by Stats. 1997, Ch. 440, Sec. 1. Effective January 1, 1998.)

10113.5. (a) An individual life insurance policy delivered or issued for delivery in this state shall contain a provision that it is incontestable after it has been in force, during the lifetime of the insured, for a period of not more than two years after its date of issue, except for nonpayment of premiums and except for any of the supplemental benefits described in Section 10271, to the extent that the contestability of those benefits is otherwise set forth in the policy or contract supplemental thereto. An individual life insurance policy, upon reinstatement, 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.

(b) (1) Notwithstanding subdivision (a), if photographic identification is presented during the application process, and if an impostor is substituted for a named insured in any part of the application process, with or without the knowledge of the named insured, then no contract between the insurer and the named insured is formed, and any purported insurance contract is void from its inception.

(2) As used in this subdivision:

(A) “Application process” means any or all of the steps required of a named insured in applying for a certificate under an individual policy of life insurance, including, but not limited to, executing any part of the application form, submitting to medical or physical examination or testing, or providing a sample or specimen of blood, urine, or other bodily substance.

(B) “Impostor” means a person other than the named insured who participates in any manner in the application process for a certificate under an individual life insurance policy and represents himself or herself to be the named insured or represents that a sample or specimen of blood, urine, or other bodily substance is that of the named insured.

(C) “Named insured” means the individual named in an application form for a certificate under an individual life insurance policy as the person whose life is to be insured.

(c) This section shall not be construed to preclude at any time the assertion of defenses based upon policy provisions that exclude or restrict coverage.

(d) This section shall not apply to individual life insurance policies delivered or issued for delivery in this state on or before December 31, 1973.

(Amended by Stats. 1998, Ch. 184, Sec. 1. Effective January 1, 1999.)

10113.6. (a) An insurer that is required to deliver a life insurance policy to the owner of the policy in order to start the period running during which the owner may exercise any statutory right to return a policy for cancellation, shall accomplish the delivery by:

(1) Registered or certified mail.

(2) Personal delivery, with a signed, written receipt of delivery.

(3) First-class mail, with a signed, written receipt of delivery.

(4) Other reasonable means, as determined by the commissioner.

(b) If an insurer does not deliver a policy by the means set forth in subdivision (a), the burden of proof shall be on the insurer to establish that the policy was delivered, in the event of a dispute with the owner of the policy.

(c) Notwithstanding subdivisions (a) and (b), a policy shall be deemed to have been received six months after the date of issuance if premiums have been paid.

(d) An employer or corporate policy owner, or the plan trustee of an employer or corporate policy owner who controls 100 or more policies, shall have the option to request in writing from an insurer the delivery of a sample policy with one or more census pages in a form satisfactory to the employer, corporate policy owner, or plan trustee, as an alternative to the delivery requirements of subdivision (a). However, delivery of the sample policy and census page as provided in this subdivision shall be subject to the provisions of subdivisions (a) and (b). The insurer shall deliver all of the policies listed on the census page to the employer, corporate policy owner, or plan trustee within 30 days of demand for delivery. The delivery of the actual policies shall not institute a new “free look” period.

(Amended by Stats. 1996, Ch. 686, Sec. 1. Effective January 1, 1997.)

10113.7. (a) An increase of premium on an individual life insurance policy that provides for premium changes by the insurer is not effective unless written notice is delivered to the policyholder, or mailed to his or her last known address as shown by the records of the insurer, not less than 20 days prior to the effective date of the increase. If the notice is sent with or contained as part of an

ordinary premium or renewal invoice or payment request, the notice of increase shall be prominently displayed and stated separately from the ordinary statement of the amount due.

(b) This section shall not apply to premium increases resulting directly from changes in coverage requested by the policyholder, or when the insurer has previously disclosed, in writing, either at the time the policy was issued or during the life of the contract, a specific date of change of premium, and the new premium amount.

(c) Nothing in this section shall be construed to limit application of any other provision of law, nor shall it be construed to prevent application of any contractual provision affording greater rights to the policyholder.

(Added by Stats. 1995, Ch. 791, Sec. 3. Effective January 1, 1996.)

10113.70. (a) (1) Whenever a flexible premium life insurance policy is subject to an adverse change in the current scale of nonguaranteed elements, as soon as practicable, but no later than 90 days before the effective date of the adverse change in the current scale of nonguaranteed elements, the insurer shall provide a summary notice and, if the policy is designated as one for which illustrations shall be used, an inforce illustration of current and future benefits and values. The illustration or illustrations shall be based on the insurer's illustrated scale after the effective date of the adverse change in the current scale of nonguaranteed elements.

(2) An inforce illustration provided pursuant to this section shall comply with the requirements of subdivisions (a) and (b) of Section 10509.955 and subdivisions (a) and (e) of Section 10509.956.

(b) The summary notice shall be in no less than 12-point type, and the illustration and summary notice shall contain the following language in boldface type: "IMPORTANT: NOTICE OF CHANGE IN NONGUARANTEED ELEMENTS OF YOUR POLICY."

(c) The summary notice shall include the information required by paragraphs (1) to (5), inclusive, and the language set forth in paragraphs (6) to (8), inclusive:

(1) The name of each nonguaranteed element in the current scale of nonguaranteed elements that is subject to an adverse change.

(2) The definition of each nonguaranteed element in the current scale of nonguaranteed elements that is subject to an adverse change.

(3) A statement identifying the current rate or charge for each nonguaranteed element and the new rate or charge for each nonguaranteed element, with reference to the current scale of nonguaranteed elements, including the percentage change in the nonguaranteed element that the adverse change represents.

(4) An explanation that the adverse change in the current scale of nonguaranteed elements is based on expectations of the future cost of providing the benefits under the policy, and that the adverse change to the current scale of nonguaranteed elements will reduce the accumulation value and may increase the risk of policy lapse based on continued payment of current premiums.

(5) The date the adverse change to the current scale of nonguaranteed elements will take effect.

(6) "Policy information:

Last policy anniversary date: ____

Next policy anniversary date: ____

Current accumulation value: ____

Current cash surrender value (accumulation value minus any surrender charges and policy loans): ____"

(7) "Your options:

Take no action: This option will reduce the accumulation of your policy. Additional premiums will be required at some point in order to maintain your coverage if not otherwise adequately funded to maintain coverage.

Pay additional premiums: You may choose to pay additional premiums starting now to maintain your policy's accumulation value and death benefit coverage for the level and period anticipated before the increase.

Reduce the face value of your policy: If your policy is not already at the minimum value specified on your policy, you may choose to reduce the specified amount on your policy to a level that will be supported by the amount and years of the premium payments you would like to pay. Please note that reducing the specified amount may result in a surrender charge.

Surrender your policy: You may choose to surrender your policy for the current cash surrender value. Before you decide to surrender your policy, you should consult your tax, insurance, or financial advisor.

Convert your policy (applicable only if your policy includes a conversion or exchange privilege in the contract): If you wish to maintain life insurance coverage but are unable to pay increased premiums to keep your policy in force, you may choose to convert your flexible premium life insurance policy to a different type of life insurance policy we offer, subject to the terms of conversions listed in your policy, which may better suit your financial needs."

(8) "We understand that you may have further questions about this change or the options available to you. You may call your agent or our customer service team at [insert customer service toll-free telephone number and hours of operation]."

(d) As used in this section:

(1) "Adverse change" means a change to the current scale of nonguaranteed elements that increases or may increase a charge, or reduces or may reduce a benefit to the policy owner, other than a change in a credited interest rate or an index account parameter based entirely on changes in the insurer's expected investment income or hedging costs.

(2) "Current scale of nonguaranteed elements" means the nonguaranteed elements, as defined in subdivision (m) of Section 10509.953, that apply to a policy in the current year and in future years, unless changed by the insurer.

(3) "Index account parameter" means a feature impacting the net credited rate for an index account, such as participation rate, cap, or spread.

(e) This section does not prohibit an insurer from including additional information in the notice that is specific to the policy for which the notice is sent, so long as it meets the requirements of this section.

(f) This section does not apply to a corporate-owned life insurance policy permitted by Section 10110.4 under which all benefits are payable to the corporate policy owner.

(g) (1) This section shall apply to a flexible premium life insurance policy in effect on or after April 1, 2019.

(2) Notwithstanding paragraph (1), the notice requirement of this section shall apply to an adverse change in the current scale of nonguaranteed elements that is scheduled to take effect on or after July 1, 2019.

(3) Notwithstanding paragraph (1), the illustration requirement of this section shall apply to an adverse change in the current scale of nonguaranteed elements that is scheduled to take effect on or after July 1, 2020.

(Added by Stats. 2018, Ch. 545, Sec. 1. (AB 2634) Effective January 1, 2019.)

10113.71. (a) Each life insurance policy issued or delivered in this state shall contain a provision for a grace period of not less than 60 days from the premium due date. The 60-day grace period shall not run concurrently with the period of paid coverage. The provision shall provide that the policy shall remain in force during the grace period.

(b) (1) A notice of pending lapse and termination of a life insurance policy shall not be effective unless mailed by the insurer to the named policy owner, a designee named pursuant to Section 10113.72 for an individual life insurance policy, and a known assignee or other person having an interest in the individual life insurance policy, at least 30 days prior to the effective date of termination if termination is for nonpayment of premium.

(2) This subdivision shall not apply to nonrenewal.

(3) Notice shall be given to the policy owner and to the designee by first-class United States mail within 30 days after a premium is due and unpaid. However, notices made to assignees pursuant to this section may be done electronically with the consent of the assignee.

(c) For purposes of this section, a life insurance policy includes, but is not limited to, an individual life insurance policy and a group life insurance policy, except where otherwise provided.

(Amended by Stats. 2013, Ch. 76, Sec. 137. (AB 383) Effective January 1, 2014.)

10113.72. (a) An individual life insurance policy shall not be issued or delivered in this state until the applicant has been given the right to designate at least one person, in addition to the applicant, to receive notice of lapse or termination of a policy for nonpayment of premium. The insurer shall provide each applicant with a form to make the designation. That form shall provide the opportunity for the applicant to submit the name, address, and telephone number of at least one person, in addition to the applicant, who is to receive notice of lapse or termination of the policy for nonpayment of premium.

(b) The insurer shall notify the policy owner annually of the right to change the written designation or designate one or more persons. The policy owner may change the designation more often if he or she chooses to do so.

(c) No individual life insurance policy shall lapse or be terminated for nonpayment of premium unless the insurer, at least 30 days prior to the effective date of the lapse or termination, gives notice to the policy owner and to the person or persons designated

pursuant to subdivision (a), at the address provided by the policy owner for purposes of receiving notice of lapse or termination. Notice shall be given by first-class United States mail within 30 days after a premium is due and unpaid.

(Added by Stats. 2012, Ch. 315, Sec. 2. (AB 1747) Effective January 1, 2013.)

10113.8. (a) Each health insurer that maintains an Internet Web site shall make a downloadable copy of the comparative benefit matrix prepared pursuant to Section 10127.14 available through a link on its site to the Internet Web sites of the department and the Department of Managed Health Care.

(b) Each health insurer shall send copies of the comparative benefit matrix on an annual basis, or more frequently as the matrix is updated by the department and the Department of Managed Health Care, to solicitors and solicitor firms and employers with whom it contracts. Each health insurer shall require its representatives and the solicitors and soliciting firms with which it contracts, to provide a copy of the comparative benefit matrix to individuals when presenting any benefit package for examination or sale.

(c) This section shall not apply to accident-only, specified disease, hospital indemnity, CHAMPUS supplement, long-term care, Medicare supplement, dental-only, or vision-only insurance policies.

(Amended by Stats. 2004, Ch. 164, Sec. 4. Effective January 1, 2005.)

10113.9. (a) This section shall not apply to vision-only, dental-only, or CHAMPUS supplement insurance, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(b) (1) A change in the premium rate or coverage for an individual health insurance policy shall not become effective unless the insurer has provided a written notice of the change at least 10 days before the start of the annual enrollment period applicable to the policy or 60 days before the effective date of the policy renewal, whichever occurs earlier in the calendar year.

(2) The written notice required pursuant to paragraph (1) shall be provided to the individual policyholder at their last address known to the insurer. The notice shall state in italics and in 12-point type the actual dollar amount of the premium increase and the specific percentage by which the current premium will be increased. The notice shall describe in plain, understandable English any changes in the policy or any changes in benefits, including a reduction in benefits or changes to waivers, exclusions, or conditions, and highlight this information by printing it in italics. The notice shall specify in a minimum of 10-point bold typeface, the reason for a premium rate change or a change in coverage or benefits.

(c) (1) If the department determines that a rate is unreasonable or not justified consistent with Article 4.5 (commencing with Section 10181), the insurer shall notify the policyholder of this determination. This notification may be included in the notice required in subdivision (b). The notification to the policyholder shall be developed by the department. The development of the notification required under this subdivision shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) The notification to the policyholder shall include the following statements in 14-point type:

(A) The Department of Insurance has determined that the rate for this product is unreasonable or not justified after reviewing information submitted to it by the insurer.

(B) During the open enrollment period, the policyholder has the option to obtain other coverage from this insurer or another insurer, or to keep this coverage.

(C) The policyholder may want to contact Covered California at www.coveredca.com for help in understanding available options.

(D) Many Californians are eligible for financial assistance from Covered California to help pay for coverage.

(3) The insurer may include in the notification to the policyholder the internet website address at which the insurer's final justification for implementing an increase that has been determined to be unreasonable by the commissioner may be found pursuant to Section 154.230 of Title 45 of the Code of Federal Regulations.

(4) The notice shall also be provided to the agent of record for the policyholder, if any, so that the agent may assist the purchaser in finding other coverage.

(5) In developing the notification, the department shall take into consideration that this notice is required to be provided to an individual applicant pursuant to subdivision (g) of Section 10181.3.

(d) (1) Before July 1, 2024, if an insurer rejects a dependent of a policyholder applying to be added to the policyholder's individual grandfathered health plan, rejects an applicant for a Medicare supplement policy due to the applicant having end-stage renal

disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, the insurer shall inform the applicant about the California Major Risk Medical Insurance Program (MRMIP) (Chapter 4 (commencing with Section 15870) of Part 3.3 of Division 9 of the Welfare and Institutions Code) and about new coverage options and the potential for subsidized coverage through Covered California. The insurer shall direct persons seeking more information to MRMIP, Covered California, plan or policy representatives, insurance agents, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

(2) On or after July 1, 2024, if an insurer rejects a dependent of a policyholder applying to be added to the policyholder's individual grandfathered health plan, rejects an applicant for a Medicare supplement policy due to the applicant having end-stage renal disease, or offers an individual grandfathered health plan to an applicant at a rate that is higher than the standard rate, the insurer shall inform the applicant about new coverage options and the potential for subsidized coverage through Covered California. The insurer shall direct persons seeking more information to Covered California, plan or policy representatives, insurance agents, or an entity paid by Covered California to assist with health coverage enrollment, such as a navigator or an assister.

(e) A notice provided pursuant to this section is a private and confidential communication and, at the time of application, the insurer shall give the applicant the opportunity to designate the address for receipt of the written notice in order to protect the confidentiality of personal or privileged information.

(f) For purposes of this section, the following definitions shall apply:

(1) "Covered California" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(2) "Grandfathered health plan" has the same meaning as that term is defined in Section 1251 of PPACA.

(3) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and rules, regulations, or guidance issued pursuant to that law.

(Amended by Stats. 2024, Ch. 40, Sec. 23. (SB 159) Effective June 29, 2024.)

10113.95. (a) A health insurer that issues, renews, or amends individual health insurance policies shall be subject to this section.

(b) An insurer subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the insurer makes its decision to provide or to deny coverage to individuals applying for coverage and sets the rate for that coverage. These guidelines, policies, or procedures shall ensure that the plan rating and underwriting criteria comply with Sections 10140 and 10291.5 and all other applicable provisions.

(c) On or before June 1, 2006, and annually thereafter, every insurer shall file with the commissioner a general description of the criteria, policies, procedures, or guidelines that the insurer uses for rating and underwriting decisions related to individual health insurance policies, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the health insurance products for which individuals applying for coverage would be eligible. An insurer may comply with this section by submitting to the department underwriting materials or resource guides provided to agents and brokers, provided that those materials include the information required to be submitted by this section.

(d) Commencing January 1, 2011, the commissioner shall post on the department's Internet Web site, in a manner accessible and understandable to consumers, general, noncompany specific information about rating and underwriting criteria and practices in the individual market and information about the California Major Risk Medical Insurance Program (Part 6.5 (commencing with Section 12700)) and the federal temporary high risk pool established pursuant to Part 6.6 (commencing with Section 12739.5). The commissioner shall develop the information for the Internet Web site in consultation with the Department of Managed Health Care to enhance the consistency of information provided to consumers. Information about individual health insurance shall also include the following notification:

"Please examine your options carefully before declining group coverage or continuation coverage, such as COBRA, that may be available to you. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely."

(e) Nothing in this section shall authorize public disclosure of company-specific rating and underwriting criteria and practices submitted to the commissioner.

(f) This section shall not apply to a closed block of business, as defined in Section 10176.10.

(g) (1) This section shall become inoperative on November 1, 2013, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become operative 12 months after the date of that repeal or amendment.

(Amended by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 1. (AB 2 1x) Effective September 30, 2013. Inoperative, by its own provisions, on November 1, 2013, subject to condition for resuming operation. See later operative version added by Sec. 2 of Ch. 1.)

10113.95. (a) A health insurer that renews individual grandfathered health benefit plans shall be subject to this section.

(b) An insurer subject to this section shall have written policies, procedures, or underwriting guidelines establishing the criteria and process whereby the insurer makes its decision to provide or to deny coverage to dependents applying for an individual grandfathered health benefit plan and sets the rate for that coverage. These guidelines, policies, or procedures shall ensure that the plan rating and underwriting criteria comply with Sections 10140 and 10291.5 and all other applicable provisions of state and federal law.

(c) On or before the June 1 next following the operative date of this section, and annually thereafter, every insurer shall file with the commissioner a general description of the criteria, policies, procedures, or guidelines that the insurer uses for rating and underwriting decisions related to individual grandfathered health benefit plans, which means automatic declinable health conditions, health conditions that may lead to a coverage decline, height and weight standards, health history, health care utilization, lifestyle, or behavior that might result in a decline for coverage or severely limit the health insurance products for which individuals applying for coverage would be eligible. An insurer may comply with this section by submitting to the department underwriting materials or resource guides provided to agents and brokers, provided that those materials include the information required to be submitted by this section.

(d) Nothing in this section shall authorize public disclosure of company-specific rating and underwriting criteria and practices submitted to the commissioner.

(e) For purposes of this section, the following definitions shall apply:

(1) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

(2) “Grandfathered health benefit plan” has the same meaning as that term is defined in Section 1251 of PPACA.

(f) (1) This section shall become operative on November 1, 2013, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become inoperative 12 months after the date of that repeal or amendment.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 2. (AB 2 1x) Effective September 30, 2013. Section operative November 1, 2013, by its own provisions. Conditionally inoperative, as prescribed by its own provisions. Upon inoperation, see the previous version, as amended by Sec. 1 of Ch. 1, which would resume operation.)

10114. Before an insurer may pay the proceeds of any contract of life or disability insurance to any undertaker or funeral director, as beneficiary or assignee, for funeral services, it shall require proof satisfactory to it that the services have been rendered. If proof of rendition of services is not furnished within thirty days after demand is made upon an insurer for such payment and in any event within one year from the date of the insured’s death, the insurer shall pay the proceeds of such insurance to any contingent or other beneficiary designated in the policy, and if no contingent or other beneficiary is so designated, to the estate of the insured or to any person, other than to such undertaker or funeral director, equitably entitled to all or any portion of the proceeds by reason of having incurred expense or furnished funeral services for the insured, to the extent of the expense incurred or services furnished.

(Added by Stats. 1939, Ch. 727.)

10115. When a payment is made equal to the full first premium at the time an application for life insurance other than group life insurance is signed by the applicant and either (1) the applicant received at that time a receipt for said payment on a form prepared by the insurer, or (2) in the absence of such a receipt the insurer receives the said payment at its home office, branch office, or the office of one of its general agencies, and in either case the insurer, pursuant to its regular underwriting practices and standards, approves the application for the issuance by it of a policy of life insurance on the plan and for the class of risk and amount of insurance applied for, and the person to be insured dies on or after the date of the application, on or after the date of the medical examination, if any, or on or after any date specially requested in the application for the policy to take effect, whichever is later, but before such policy is issued and delivered, the insurer shall pay such amount as would have been due under the terms of the policy

in the same manner and subject to the same rights, conditions and defenses as if such policy had been issued and delivered on the date the application was signed by the applicant. The provisions of this section shall not prohibit an insurer from limiting the maximum amount for which it may be liable prior to actual issuance and delivery of the policy of life insurance either to (1) an amount not less than its established maximum retention, or to (2) fifty thousand dollars ($50,000), if a statement to this effect is included in the application.

(Amended by Stats. 1951, Ch. 53.)

10116. No group life insurance policy or disability insurance policy shall be issued or delivered in this State where the premiums or any part thereof is paid or is to be paid in whole or in part by an employer pursuant to the terms of a collective bargaining agreement unless the policy provides that in the event of a cessation of work by the employees covered by the policy as the result of a labor dispute the policy, upon timely payment of the premium, shall continue in effect with respect to all 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, for the period of cessation of work, under the following conditions:

(a) If the policyholder is not a trustee or the trustees of a fund established or maintained in whole or in part by the employer, the policy shall provide that the employee's individual contribution shall be 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. If the policy does not provide for a rate applicable to individuals, the policy shall provide that the employee's individual contribution shall be an amount equal to the amount determined by dividing (1) the total monthly premium in effect under the policy at the date of cessation of work by (2) the total number of persons insured under the policy at such date.

(b) If the policyholder is a trustee or the trustees of a fund established or maintained in whole or in part by the employer, the employee's contribution shall be the amount which he and his employer would have been required to contribute to the trust for such employee if (1) the cessation of work had not occurred and (2) the agreement requiring the employer to make contributions to the trust were in full force.

(c) The policy may provide that the continuation of insurance is contingent upon the collection of individual contributions by the union or unions representing the employees for policies referred to in subdivision (a) above, and by the policyholder or the policyholder's agent with respect to policies referred to in subdivision (b) above.

(d) The policy may provide that the continuation of insurance on each employee is contingent upon timely payment of contributions by the individual and timely payment of the premium by the entity responsible for collecting the individual contributions.

(e) The policy may provide that each individual premium rate shall be increased by any amount up to twenty percent (20%), or any higher percent which may be approved by the commissioner, of that otherwise shown in the policy during the period of cessation of work in order to provide sufficient compensation to the insurer to cover increased administrative costs and increased mortality and morbidity. If the policy does provide for such an increase, this shall have the effect of increasing the employee's contribution by a like percent.

(f) Nothing in this section shall be deemed to limit any right which the insurer may have in accordance with the terms of the policy to increase or decrease the premium rates before, during or after such cessation of work if, in fact, the insurer would have had the right to increase the premium rate had the cessation of work not occurred. If such a premium rate change is made, it shall be effective, notwithstanding any other provisions of this section, on such date as the insurer shall determine in accordance with the terms of the policy.

(g) The policy may contain such other provisions with respect to such continuation of insurance as the commissioner may approve.

(h) The policy may provide that, if a premium is unpaid at the date of cessation of work and such premium became due prior to such cessation of work, the continuation of insurance is contingent upon payment of such premium prior to the date the next premium becomes due under the terms of the policy.

Nothing herein shall be deemed to require the continuation of any loss of time payments included in any such group disability policy, nor of any other coverages beyond the time that seventy-five percent (75%) of the employees continue such coverage or as to any individual employee beyond the time that he takes full-time employment with another employer; nor shall anything herein be deemed to require continuation of coverage more than six (6) months after the cessation of work.

Nothing in this section shall be construed as modifying or in any way affecting the operation and effect of the provisions of Part 2 of Division 1 of the Unemployment Insurance Code.

(Added by Stats. 1961, Ch. 2097.)

10116.5. (a) Every policy of disability insurance that is issued, amended, delivered, or renewed in this state on or after January 1, 1999, that provides hospital, medical, or surgical expense coverage under an employer-sponsored group plan for an employer subject to COBRA, as defined in subdivision (e), or an employer group for which the disability insurer is required to offer Cal-COBRA coverage, as defined in subdivision (f), including a carrier providing replacement coverage under Section 10128.3, shall further offer

the former employee the opportunity to continue benefits as required under subdivision (b), and shall further offer the former spouse of an employee or former employee the opportunity to continue benefits as required under subdivision (c).

(b) (1) If a former employee worked for the employer for at least five years prior to the date of termination of employment and is 60 years of age or older on the date employment ends is entitled to and so elects to continue benefits under COBRA or Cal-COBRA for himself or herself and for any spouse, the employee or spouse may further continue benefits beyond the date coverage under COBRA or Cal-COBRA ends, as set forth in paragraph (2). Except as otherwise specified in this section, continuation coverage shall be under the same benefit terms and conditions as if the continuation coverage under COBRA or Cal-COBRA had remained in force. For the employee or spouse, continuation coverage following the end of COBRA or Cal-COBRA is subject to payment of premiums to the insurer. Individuals ineligible for COBRA or Cal-COBRA or who are eligible but have not elected or exhausted continuation coverage under federal COBRA or Cal-COBRA are not entitled to continuation coverage under this section. Premiums for continuation coverage under this section shall be billed by, and remitted to, the insurer in accordance with subdivision (d). Failure to pay the requisite premiums may result in termination of the continuation coverage in accordance with the applicable provisions in the insurer's group contract with the employer.

(2) The employer shall notify the former employee or spouse or both, or the former spouse of the employee or former employee, of the availability of the continuation benefits under this section in accordance with Section 2800.2 of the Labor Code. To continue health care coverage pursuant to this section, the individual shall elect to do so by notifying the insurer in writing within 30 calendar days prior to the date continuation coverage under COBRA or Cal-COBRA is scheduled to end. Every disability insurer shall provide to the employer replacing a group benefit plan policy issued by the insurer, or to the employer's agent or broker representative, within 15 days of any written request, information in possession of the insurer reasonably required to administer the requirements of Section 2800.2 of the Labor Code.

(3) The continuation coverage shall end automatically on the earlier of (A) the date the individual reaches age 65, (B) the date the individual is covered under any group health plan not maintained by the employer or any other insurer or health care service plan, regardless of whether that coverage is less valuable, (C) the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act, (D) for a spouse, five years from the date on which continuation coverage under COBRA or Cal-COBRA was scheduled to end for the spouse, or (E) the date on which the employer terminates its group contract with the insurer and ceases to provide coverage for any active employees through that insurer, in which case the insurer shall notify the former employee or spouse, or both, of the right to a conversion policy.

(c) (1) If a former spouse of an employee or former employee was covered as a qualified beneficiary under COBRA or Cal-COBRA, the former spouse may further continue benefits beyond the date coverage under COBRA or Cal-COBRA ends, as set forth in paragraph (2) of subdivision (b). Except as otherwise specified in this section, continuation coverage shall be under the same benefit terms and conditions as if the continuation coverage under COBRA or Cal-COBRA had remained in force. Continuation coverage following the end of COBRA or Cal-COBRA is subject to payment of premiums to the insurer. Premiums for continuation coverage under this section shall be billed by, and remitted to, the insurer in accordance with subdivision (d). Failure to pay the requisite premiums may result in termination of the continuation coverage in accordance with the applicable provisions in the insurer's group contract with the employer or former employer.

(2) The continuation coverage for the former spouse shall end automatically on the earlier of (A) the date the individual reaches 65 years of age, (B) the date the individual is covered under any group health plan not maintained by the employer or any other health care service plan or insurer, regardless of whether that coverage is less valuable, (C) the date the individual becomes entitled to Medicare under Title XVIII of the Social Security Act, (D) five years from the date on which continuation coverage under COBRA or Cal-COBRA was scheduled to end for the former spouse, or (E) the date on which the employer or former employer terminates its group contract with the insurer and ceases to provide coverage for any active employees through that insurer.

(d) (1) If the premium charged to the employer for a specific employee or dependent eligible under this section is adjusted for the age of the specific employee, or eligible dependent, on other than a composite basis, the rate for continuation coverage under this section shall not exceed 102 percent of the premium charged by the insurer to the employer for an employee of the same age as the former employee electing continuation coverage in the case of an individual who was eligible for COBRA, and 110 percent in the case of an individual who was eligible for Cal-COBRA. If the coverage continued is that of a former spouse, the premium charged shall not exceed 102 percent of the premium charged by the plan to the employer for an employee of the same age as the former spouse selecting continuation coverage in the case of an individual who was eligible for COBRA, and 110 percent in the case of an individual who was eligible for Cal-COBRA.

(2) If the premium charged to the employer for a specific employee or dependent eligible under this section is not adjusted for age of the specific employee, or eligible dependent, then the rate for continuation coverage under this section shall not exceed 213 percent of the applicable current group rate. For purposes of this section, the "applicable current group rate" means the total premiums charged by the insurer for coverage for the group, divided by the relevant number of covered persons.

(3) However, in computing the premiums charged to the specific employer group, the insurer shall not include consideration of the specific medical care expenditures for beneficiaries receiving continuation coverage pursuant to this section.

(e) For purposes of this section, “COBRA” means Section 4980B of Title 26, Section 1161 and following of Title 29, and Section 300bb of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), and as amended.

(f) For purposes of this section, “Cal-COBRA” means the continuation coverage that must be offered pursuant to Article 1.7 (commencing with Section 10128.50), or Article 4.5 (commencing with Section 1366.20) of Chapter 2.2 of Division 2 of the Health and Safety Code.

(g) For the purposes of this section, “former spouse” means either an individual who is divorced from an employee or former employee or an individual who was married to an employee or former employee at the time of the death of the employee or former employee.

(h) Every group benefit plan evidence of coverage that is issued, amended, or renewed after January 1, 1999, shall contain a description of the provisions and eligibility requirements for the continuation coverage offered pursuant to this section.

(i) This section does not apply to any individual who is not eligible for its continuation coverage prior to January 1, 2005.

(Amended by Stats. 2013, Ch. 441, Sec. 13. (AB 1180) Effective October 1, 2013.)

10117. (a) A policy of disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital service plan may not provide an exception for other coverage where the other coverage is entitlement to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14500) of Part 3 of Division 9 of the Welfare and Institutions Code, or medicaid benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code. Each policy of disability insurance shall be interpreted not to provide an exception for those Medi-Cal or medicaid benefits.

(b) A policy of disability insurance may not provide that the benefits payable thereunder are subject to reduction if the individual insured has entitlement to such Medi-Cal benefits.

(c) A policy of disability insurance, self-insured employee welfare benefit plan, or nonprofit hospital service plan shall not provide an exception for enrollment for benefits because of an applicant’s entitlement to Medi-Cal benefits under Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14500) of Part 3 of Division 9 of the Welfare and Institutions Code, or medicaid benefits under Subchapter 19 (commencing with Section 1396) of Chapter 7 of Title 42 of the United States Code.

(Amended by Stats. 1994, Ch. 147, Sec. 10. Effective July 11, 1994.)

10117.5. No disability insurer contract that covers hospital, medical, or surgical benefits that is issued, amended, renewed, or delivered on and after January 1, 2002, shall contain a provision that prohibits or restricts any health facilities’ compliance with the requirements of Section 1262.5 of the Health and Safety Code.

(Added by Stats. 2001, Ch. 691, Sec. 6. Effective January 1, 2002.)

10117.52. (a) No health insurance contract in existence or issued, amended, or renewed on or after January 1, 2013, between a health insurer and a provider or a supplier shall prohibit, condition, or in any way restrict the disclosure of claims data related to health care services provided to a policyholder or insured of the insurer or beneficiaries of any self-insured health coverage arrangement administered by the insurer, to a qualified entity, as defined in Section 1395kk(e)(2) of Title 42 of the United States Code. All disclosures of data made under this section shall comply with all applicable state and federal laws for the protection of the privacy and security of the data, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191) and the federal Health Information Technology for Economic and Clinical Health Act, Title XIII of the federal American Recovery and Reinvestment Act of 2009 (Public Law 111-5), and implementing regulations.

(b) For purposes of this section, the following definitions apply:

(1) “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(2) “Provider” means a hospital, a skilled nursing facility, a comprehensive outpatient rehabilitation facility, a home health agency, a hospice, a clinic, or a rehabilitation agency.

(3) “Supplier” means a physician and surgeon or other health care practitioner, or an entity that furnishes health care services other than a provider.

(Added by Stats. 2012, Ch. 869, Sec. 3. (SB 1196) Effective January 1, 2013.)

10118. A policy of disability insurance delivered or issued for delivery in this state more than 120 days after the effective date of this section, that provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract, shall also provide in substance that attainment of the limiting age shall not operate to terminate the

coverage of the child while the child is and continues to be both (a) incapable of self-sustaining employment by reason of an intellectual disability or physical handicap and (b) chiefly dependent upon the insured for support and maintenance, provided proof of the incapacity and dependency is furnished to the insurer by the insured within 31 days of the child's attainment of the limiting age and subsequently as may be required by the insurer, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

Disability policies currently approved by the commissioner that are delivered or issued for delivery more than 120 days after the effective date of this section shall be automatically construed to be in compliance with this section and need not be refiled or reprinted. Disability policies submitted to the commissioner for approval on and after the effective date of this section shall contain provisions in compliance with this section.

(Amended by Stats. 2012, Ch. 457, Sec. 36. (SB 1381) Effective January 1, 2013.)

10119. On and after the operative date of this section:

(a) No policy of disability insurance which, in addition to covering the insured, also covers members of the insured's immediate family, may be issued or amended in this state if it contains any disclaimer, waiver, or other limitation of coverage relative to the accident and sickness coverage or insurability of newborn infants of an insured from and after the moment of birth or of any minor child placed with an insured for adoption from and after the moment the child is placed in the physical custody of the insured for adoption.

(b) Each such policy of disability insurance shall contain a provision granting immediate accident and sickness coverage to each newborn infant of, and each minor child placed for adoption with, any insured as required by subdivision (a).

(c) A policy of disability insurance, self-insured care coverage, employee welfare benefit plan, or nonprofit hospital service plan, shall comply with the standards set forth in Chapter 7 (commencing with Section 3750) of Part 1 of Division 9 of the Family Code and Section 14124.94 of the Welfare and Institutions Code.

(Amended by Stats. 1996, Ch. 1062, Sec. 20. Effective January 1, 1997.)

10119.1. (a) This section shall apply to a health insurer that covers hospital, medical, or surgical expenses under an individual health benefit plan, as defined in subdivision (a) of Section 10198.6, that is issued, amended, renewed, or delivered on or after January 1, 2007.

(b) At least once each year, a health insurer shall permit an individual who has been covered for at least 18 months under an individual health benefit plan to transfer, without medical underwriting, to any other individual health benefit plan offered by that same health insurer that provides equal or lesser benefits as determined by the insurer.

"Without medical underwriting" means that the health insurer shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual who transfers to another individual health benefit plan pursuant to this section.

(c) The insurer shall establish, for the purposes of subdivision (b), a ranking of the individual health benefit plans it offers to individual purchasers and post the ranking on its Internet Web site or make the ranking available upon request. The insurer shall update the ranking whenever a new benefit design for individual purchasers is approved.

(d) The insurer shall notify in writing all insureds of the right to transfer to another individual health benefit plan pursuant to this section, at a minimum, when the insurer changes the insured's premium rate. Posting this information on the insurer's Internet Web site shall not constitute notice for purposes of this subdivision. The notice shall adequately inform insureds of the transfer rights provided under this section including information on the process to obtain details about the individual health benefit plans available to that insured and advising that the insured may be unable to return to his or her current individual health benefit plan if the insured transfers to another individual health benefit plan.

(e) The requirements of this section shall not apply to the following:

(1) A federally eligible defined individual, as defined in subdivision (e) of Section 10900, who purchases individual coverage pursuant to Section 10785.

(2) An individual offered conversion coverage pursuant to Sections 12672 and 12682.1.

(3) An individual enrolled in the Medi-Cal program pursuant to Chapter 7 (commencing with Section 14000) of Part 3 of Division 9 of the Welfare and Institutions Code.

(4) An individual enrolled in the Access for Infants and Mothers Program, pursuant to Part 6.3 (commencing with Section 12695).

(5) An individual enrolled in the Healthy Families Program pursuant to Part 6.2 (commencing with Section 12693).

(f) It is the intent of the Legislature that individuals shall have more choice in their health care coverage when health insurers guarantee the right of an individual to transfer to another product based on the insurer's own ranking system. The Legislature does not intend for the department to review or verify the insurer's ranking for actuarial or other purposes.

(g) (1) This section shall become inoperative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become operative 12 months after the date of that repeal or amendment.

(Amended by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 3. (AB 2 1x) Effective September 30, 2013. Inoperative, by its own provisions, on January 1, 2014, subject to condition for resuming operation.)

10119.2. (a) Every health insurer that offers, issues, or renews health insurance under an individual health benefit plan, as defined in subdivision (a) of Section 10198.6, shall offer to any individual, who was covered under an individual health benefit plan that was rescinded, a new individual health benefit plan without medical underwriting that provides equal benefits. A health insurer may also permit an individual, who was covered under an individual health benefit plan that was rescinded, to remain covered under that individual health benefit plan, with a revised premium rate that reflects the number of persons remaining on the health benefit plan.

(b) "Without medical underwriting" means that the health insurer shall not decline to offer coverage to, or deny enrollment of, the individual or impose any preexisting condition exclusion on the individual who is issued a new individual health benefit plan or remains covered under an individual health benefit plan pursuant to this section.

(c) If a new individual health benefit plan is issued, the insurer may revise the premium rate to reflect only the number of persons covered under the new individual health benefit plan.

(d) Notwithstanding subdivisions (a) and (b), if an individual was subject to a preexisting condition provision or a waiting or affiliation period under the individual health benefit plan that was rescinded, the health insurer may apply the same preexisting condition provision or waiting or affiliation period in the new individual health benefit plan. The time period in the new individual health benefit plan for the preexisting condition provision or waiting or affiliation period shall not be longer than the one in the individual health benefit plan that was rescinded and the health insurer shall credit any time that the individual was covered under the rescinded individual health benefit plan.

(e) The insurer shall notify in writing all insureds of the right to coverage under an individual health benefit plan pursuant to this section, at a minimum, when the insurer rescinds the individual health benefit plan. The notice shall adequately inform insureds of the right to coverage provided under this section.

(f) The insurer shall provide 60 days for insureds to accept the offered new individual health benefit plan and this plan shall be effective as of the effective date of the original individual health benefit plan and there shall be no lapse in coverage.

(g) This section shall not apply to any individual whose information in the application for coverage and related communications led to the rescission.

(h) (1) This section shall become inoperative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become operative 12 months after the date of that repeal or amendment.

(Amended by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 4. (AB 2 1x) Effective September 30, 2013. Inoperative, by its own provisions, on January 1, 2014, subject to condition for resuming operation. See later operative version added by Sec. 5 of Ch. 1.)

10119.2. (a) Every health insurer that offers, issues, or renews health insurance under an individual health benefit plan, as defined in subdivision (a) of Section 10198.6, shall offer to any individual, who was covered by the insurer under an individual health benefit plan that was rescinded, a new individual health benefit plan that provides the most equivalent benefits.

(b) A health insurer that offers, issues, or renews individual health benefit plans inside or outside the California Health Benefit Exchange may also permit an individual, who was covered by the insurer under an individual health benefit plan that was rescinded, to remain covered under that individual health benefit plan, with a revised premium rate that reflects the number of persons remaining on the health benefit plan consistent with Section 10965.9.

(c) If a new individual health benefit plan is issued under subdivision (a), the insurer may revise the premium rate to reflect only the number of persons covered on the new individual health benefit plan consistent with Section 10965.9.

(d) The insurer shall notify in writing all insureds of the right to coverage under an individual health benefit plan pursuant to this section, at a minimum, when the insurer rescinds the individual health benefit plan. The notice shall adequately inform insureds of

the right to coverage provided under this section.

(e) The insurer shall provide 60 days for insureds to accept the offered new individual health benefit plan under subdivision (a), and this plan shall be effective as of the effective date of the original health benefit plan and there shall be no lapse in coverage.

(f) This section shall not apply to any individual whose information in the application for coverage and related communications led to the rescission.

(g) This section shall apply notwithstanding subdivision (a) or (d) of Section 10965.3.

(h) (1) This section shall become operative on January 1, 2014, or the 91st calendar day following the adjournment of the 2013–14 First Extraordinary Session, whichever date is later.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-4), this section shall become inoperative 12 months after the date of that repeal or amendment.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 5. (AB 2 1x) Effective September 30, 2013. Section operative January 1, 2014, by its own provisions. Conditionally inoperative, as prescribed by its own provisions. Upon inoperation, see the previous version, as amended by Sec. 4 of Ch. 1, which would resume operation.)

10119.3. (a) Notwithstanding any other provision of law, an agent or broker who assists an applicant in submitting an application to a health insurer has the duty to assist the applicant in providing answers to health questions accurately and completely.

(b) An agent or broker who assists an applicant in submitting an application to a health insurer shall attest on the written application to both of the following:

(1) That to the best of his or her knowledge, the information on the application is complete and accurate.

(2) That he or she explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and that the applicant understood the explanation.

(c) If, in an attestation required by subdivision (b), a declarant willfully states as true any material fact he or she knows to be false, that person shall, in addition to any applicable penalties or remedies available under current law, be subject to a civil penalty of up to ten thousand dollars ($10,000). Any public prosecutor may bring a civil action to impose that civil penalty. These penalties shall be paid to the Insurance Fund.

(d) A health insurance application shall include a statement advising declarants of the civil penalty authorized under this section.

(Added by Stats. 2008, Ch. 604, Sec. 4. Effective January 1, 2009.)

10119.5. (a) No individual or group policy of health insurance that is issued, amended, renewed, or delivered on or after July 1, 2003, that provides maternity coverage shall contain a copayment or deductible for inpatient hospital maternity services that exceeds the most common amount of the copayment or deductible contained in the policy for inpatient services provided for other covered medical conditions or contain a copayment or deductible for ambulatory care maternity services that exceeds the most common amount of the copayment or deductible contained in the policy for ambulatory care services provided for other covered medical conditions.

(b) No group or blanket policy of health insurance that provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions, as to involuntary complications of pregnancy, unless the provisions apply generally to all benefits paid under the policy.

(c) For purposes of this section, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

(d) This section shall not apply to Medicare supplement, vision-only, or Champus-supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(e) This section shall not permit copayments or deductibles in the Medi-Cal program that are not otherwise authorized under state or federal law.

(f) This section shall become operative on July 1, 2003.

(Repealed (in Sec. 4) and added by Stats. 2002, Ch. 880, Sec. 5. Effective January 1, 2003. Section operative July 1, 2003, by its own provisions.)

10119.6. (a) (1) A large group disability insurance policy, except a specialized disability insurance policy, that is issued, amended, or renewed on or after January 1, 2026, shall provide coverage for the diagnosis and treatment of infertility and fertility services, including a maximum of three completed oocyte retrievals with unlimited embryo transfers in accordance with the guidelines of the American Society for Reproductive Medicine (ASRM), using single embryo transfer when recommended and medically appropriate.

(2) A small group disability insurance policy, except a disability insurance policy described in paragraph (4), that is issued, amended, or renewed on or after January 1, 2026, shall offer coverage for the diagnosis and treatment of infertility and fertility services. This paragraph shall not be construed to require a small group disability insurance policy to provide coverage for infertility services.

(3) A disability insurer shall include notice of the coverage specified in this section in the insurer's evidence of coverage.

(4) This section shall not apply to accident-only, specified disease, hospital indemnity, Medicare supplement, or specialized disability insurance policies.

(b) For purposes of this section, "infertility" means a condition or status characterized by any of the following:

(1) A licensed physician's findings, based on a patient's medical, sexual, and reproductive history, age, physical findings, diagnostic testing, or any combination of those factors. This definition shall not prevent testing and diagnosis before the 12-month or 6-month period to establish infertility in paragraph (3).

(2) A person's inability to reproduce either as an individual or with their partner without medical intervention.

(3) The failure to establish a pregnancy or to carry a pregnancy to live birth after regular, unprotected sexual intercourse. For purposes of this section "regular, unprotected sexual intercourse" means no more than 12 months of unprotected sexual intercourse for a person under 35 years of age or no more than 6 months of unprotected sexual intercourse for a person 35 years of age or older. Pregnancy resulting in miscarriage does not restart the 12-month or 6-month time period to qualify as having infertility.

(c) The policy may not include any of the following:

(1) Any exclusion, limitation, or other restriction on coverage of fertility medications that are different from those imposed on other prescription medications.

(2) Any exclusion or denial of coverage of any fertility services based on a covered individual's participation in fertility services provided by or to a third party. For purposes of this section, "third party" includes an oocyte, sperm, or embryo donor, gestational carrier, or surrogate that enables an intended recipient to become a parent.

(3) Any deductible, copayment, coinsurance, benefit maximum, waiting period, or any other limitation on coverage for the diagnosis and treatment of infertility, except as provided in subdivision (a) that are different from those imposed upon benefits for services not related to infertility.

(d) This section does not in any way deny or restrict any existing right or benefit to coverage and treatment of infertility or fertility services under an existing law, plan, or policy.

(e) This section applies to every disability insurance policy that is issued, amended, or renewed to residents of this state regardless of the situs of the contract.

(f) Consistent with Section 10140, coverage for the treatment of infertility and fertility services shall be provided without discrimination on the basis of age, ancestry, color, disability, domestic partner status, gender, gender expression, gender identity, genetic information, marital status, national origin, race, religion, sex, or sexual orientation. This subdivision shall not be construed to interfere with the clinical judgment of a physician and surgeon.

(g) This section shall not apply to a religious employer, as defined in Section 10123.196.

(h) This section shall not apply to a health care benefit plan or policy entered into with the Board of Administration of the Public Employees' Retirement System pursuant to the Public Employees' Medical and Hospital Care Act (Part 5 (commencing with Section 22750) of Division 5 of Title 2 of the Government Code) until July 1, 2027.

(i) (1) Until January 1, 2027, the commissioner may issue guidance regarding compliance with this section, and that guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(2) The department shall consult with the Department of Managed Health Care and stakeholders in issuing the guidance specified in paragraph (1).

(Amended by Stats. 2025, Ch. 21, Sec. 46. (AB 116) Effective June 30, 2025.)

10119.7. No group or individual policy of disability insurance which covers hospital, medical, or surgical expenses shall be issued, amended, delivered, or renewed in this state on or after January 1, 1981, if it contains any exclusion, reduction, or other limitations, as to coverage, deductibles, or coinsurance provisions applicable solely to conditions attributable to diethylstilbestrol or exposure to diethylstilbestrol.

All policies subject to this section and issued, amended, delivered, or renewed in this state on or after January 1, 1981, shall be construed to be in compliance with this section, and any provision in any such policy which is in conflict with this section shall be of no force or effect.

(Added by Stats. 1980, Ch. 776, Sec. 3.)

10119.8. On and after January 1, 1993, every insurer issuing, amending, or renewing a policy of individual or group disability insurance that covers hospital, medical, or surgical expenses shall offer coverage for screening for blood lead levels for covered children. This section shall not apply to specified accident, specified disease, hospital indemnity, Medicare supplement, or long-term care health insurance policies.

(Added by Stats. 1991, Ch. 797, Sec. 2.)

10119.9. (a) A disability insurance policy or certificate covering hospital, surgical, or medical expenses, that meets the definition of "health benefit plan" in subdivision (a) of Section 10198.6, that is issued, amended, renewed, or delivered on or after January 1, 2000, shall be deemed to cover general anesthesia and associated facility charges for dental procedures rendered in a hospital or surgery center setting, when the clinical status or underlying medical condition of the insured requires dental procedures that ordinarily would not require general anesthesia to be rendered in a hospital or surgery center setting. The disability insurance policy or certificate may require prior authorization of general anesthesia and associated charges required for dental care procedures in the same manner that prior authorization is required for other covered diseases or conditions.

(b) This section shall apply only to general anesthesia and associated facility charges for only the following insureds, and only if the insureds meet the criteria in subdivision (a):

(1) Insureds who are under seven years of age.

(2) Insureds who are developmentally disabled, regardless of age.

(3) Insureds whose health is compromised and for whom general anesthesia is medically necessary, regardless of age.

(c) Nothing in this section shall require insurers to cover any charges for the dental procedure itself, including the professional fee of the dentist. Coverage for anesthesia and associated facility charges pursuant to this section shall be subject to all other terms and conditions of the policy or certificate that apply generally to other benefits.

(d) Nothing in this section shall require insurers to cover anesthesia or related facility charges for dental procedures that ordinarily would require general anesthesia and that do not meet the requirements of subdivision (a), (b), or (c).

(e) A disability insurance policy may include coverage specified in subdivision (a) at any time prior to January 1, 2000.

(Added by Stats. 1998, Ch. 790, Sec. 2. Effective January 1, 1999.)

10120. If a policy of disability insurance issued, issued for delivery, or renewed in this state after the effective date of this section provides in any manner for payment of all or part of the cost of a "sterilization operation or procedure" any exclusion, reduction, or limitation on such a benefit based upon the reason, or reasons, of the covered persons for requesting such sterilization shall be void and of no effect.

All disability policies issued, issued for delivery, or renewed in this state after effective date of this section shall be automatically construed to be in compliance with this section and need not be refiled or reprinted.

As used in this code, "sterilization operations or procedures" shall include and mean any operation or procedure altering the human body which has as its purpose, or one of its purposes, the temporary or permanent prevention of procreation by either a male or a female.

(Added by Stats. 1970, Ch. 1128.)

10120.2. (a) This section shall only apply to a disability insurer that issues a dental insurance policy pursuant to this part.

(b) For purposes of this section, the following terms have the following meanings:

(1) "Coordination of benefits" means the method by which a disability insurer and one or more other disability insurers, health care service plans covering dental services, or specialized health care service plans, covering dental services, pay their respective reimbursements for dental benefits when an insured is covered by multiple disability insurers, or a combination of disability insurers and health care service plans or specialized health care service plans.

(2) "Primary dental benefit plan" means a dental insurance policy issued by a disability insurer regulated pursuant to this part or a health care service plan or specialized health care service plan contract regulated pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code that provides an insured or enrollee with primary dental coverage.

(3) “Secondary dental benefit plan” means a dental insurance policy issued by a disability insurer regulated pursuant to this part or a health care service plan or specialized health care service plan contract regulated pursuant to Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code that provides an insured or enrollee with secondary dental coverage.

(c) A disability insurer that issues a dental insurance policy shall declare its coordination of benefits policy prominently in its evidence of coverage or insurance policy with both insured and policyholder.

(d) When a primary dental benefit plan is coordinating its benefits with one or more secondary dental benefit plans, it shall pay the maximum amount required by its policy with the insured or policyholder.

(e) A disability insurer that issues a dental insurance policy, when acting as a secondary dental benefit plan or insurer, shall pay the lesser of either the amount it would have paid in the absence of any other dental benefit coverage, or the insured’s total out-of-pocket cost payable under the primary dental benefit plan for benefits covered under the secondary plan or policy.

(f) Nothing in this section is intended to conflict with or modify the way in which a disability insurer that issues a dental insurance policy determines which dental benefit plan is primary and which is secondary in coordinating benefits with another insurer or plan pursuant to existing state law or regulation.

(Added by Stats. 2007, Ch. 164, Sec. 3. Effective January 1, 2008.)

10120.3. (a) With respect to a contract between an insurer covering dental services and a dentist to provide covered dental services to insureds, the contract shall not require a dentist to accept an amount set by the insurer as payment for dental care services provided to an insured that are not covered services under the insured’s policy. This subdivision shall only apply to provider contracts issued, amended, or renewed on or after January 1, 2011.

(b) A provider shall not charge more for dental services that are not covered services under a health insurance policy than his or her usual and customary rate for those services. The department shall not be required to enforce this subdivision.

(c) The evidence of coverage and disclosure form, or combined evidence of coverage and disclosure form, for every health insurance policy covering dental services, or specialized health insurance policy covering dental services, that is issued, amended, or renewed on or after July 1, 2011, shall include the following statement:

IMPORTANT: If you opt to receive dental services that are not covered services under this policy, a participating dental provider may charge you his or her usual and customary rate for those services. Prior to providing a patient with dental services that are not a covered benefit, the dentist should provide to the patient a treatment plan that includes each anticipated service to be provided and the estimated cost of each service. If you would like more information about dental coverage options, you may call member services at [insert appropriate telephone number] or your insurance broker. To fully understand your coverage, you may wish to carefully review this evidence of coverage document.

(d) For purposes of this section, “covered services” or “covered dental services” means dental care services for which the insurer is obligated to pay pursuant to an insured’s policy, or for which the insurer would be obligated to pay pursuant to an insured’s policy but for the application of contractual limitations such as deductibles, copayments, coinsurance, waiting periods, annual or lifetime maximums, frequency limitations, or alternative benefit payments.

(Amended by Stats. 2011, Ch. 296, Sec. 188. (AB 1023) Effective January 1, 2012.)

10120.35. (a) Notwithstanding any other law, a health insurer, including a specialized health insurer and a health insurer that issues, sells, renews, or offers a contract covering dental services, shall reimburse its contracting health care providers for business expenses to prevent the spread of diseases causing public health emergencies declared on or after January 1, 2022. For purposes of this subdivision, “business expenses” means personal protective equipment, additional supplies, materials, and clinical staff time over and above those expenses usually included in an office visit or other nonfacility service or services if performed during a public health emergency, as defined by law, due to respiratory-transmitted infectious disease and pursuant to subdivision (b).

(b) A health insurer shall reimburse a contracting health care provider pursuant to subdivision (a) for each individual patient encounter, limited to one encounter per day per insured for the duration of the public health emergency.

(c) The department shall ensure a health insurer provides timely reimbursement to its contracting health care providers pursuant to subdivision (a). The department may adopt guidance to implement this section. The guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(d) For purposes of this section, “contracting health care provider” means a physician and surgeon, dentist, or doctor of podiatric medicine who is licensed by the state to deliver or furnish health care services, who owns or operates a practice, and who is contracted with the insured’s health insurer. The term “contracting health care provider” only applies to a dentist if the insured is covered by a health insurance policy or specialized health insurance policy that includes dental benefits.

(e) This section does not apply to the state of emergency declared by the Governor on March 4, 2020, relating to the coronavirus 2019 (COVID-19) pandemic.

(f) This section shall not apply to a Medi-Cal managed care plan that contracts with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) of, Chapter 8 (commencing with Section 14200) of, or Chapter 8.75 (commencing with Section 14591) of, Part 3 of Division 9 of the Welfare and Institutions Code.

(Added by Stats. 2021, Ch. 538, Sec. 2. (SB 242) Effective January 1, 2022.)

10120.4. (a) A health insurer that issues, sells, renews, or offers a policy covering dental services, including a specialized policy of health insurance covering dental services, or a contracting entity may grant a third party access to a provider network contract, or a provider's dental services or contractual discounts provided pursuant to a provider network contract if the requirements of subdivisions (b) and (c) are met.

(b) A health insurer that issues, sells, renews, or offers a policy covering dental services may grant a third party access to a provider network contract if, at the time the provider network contract is entered into, and at any time a notice is sent to a health care provider as required pursuant to Section 10133.65, the provider network contract allows a provider to choose not to participate in third-party access to the provider network contract. The third-party access provision of the provider network contract shall be clearly identified. An insurer shall not grant third-party access to the provider network contract of a provider that does not participate in third-party access to the provider network contract.

(c) A contracting entity may grant a third party access to a provider network contract, or a provider's dental services or contractual discounts provided pursuant to a provider network contract, if all of the following are met:

(1) The provider network contract specifically states that the contracting entity may enter into an agreement with a third party that would allow the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity, and when the contracting entity is a health insurer, the provider chose to participate in third-party access at the time the provider network contract was entered into.

(2) If the contracting entity is a health insurer, the third-party access provision of the provider network contract shall clearly identify in the contract and notice to the provider, as required pursuant to Section 10133.65, the following language conspicuously placed on the first page of the document in 12-point underlined type:

This contract grants third-party access to the provider network. The provider network contracting entity has entered into an agreement with other dental insurers or third parties that allows the third party to obtain the contracting entity's rights and responsibilities as if the third party were the contracting entity. The list of all third parties with access to this provider network can be found at (insert internet website as identified in paragraph (4)). You have the right to choose not to participate in third-party access. To exercise your right to not participate in the third-party access, submit your written or electronic request to the health insurer.

(3) The contracting entity identifies prior to signing the contract, in writing or electronic format to the provider, all third parties in existence as of the date the provider network contract is entered into.

(4) The contracting entity identifies all third parties in existence in a list on its internet website that is updated at least once every 90 days.

(5) (A) The contracting entity requires a third party to identify the source of the discount on all written or electronic remittance advices or explanations of payment under which a discount is taken.

(B) This paragraph does not apply to electronic transactions mandated by the Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191).

(6) A third party's right to a provider's discounted rate ceases as of the termination date of the provider network contract.

(7) The contracting entity makes available a copy of the provider network contract relied on in the adjudication of a claim to a participating provider within 30 days of a request from the provider.

(d) A provider is not bound by or required to perform dental treatment or services under a provider network contract granted to a third party in violation of this section.

(e) This section does not apply if any of the following criteria are met:

(1) The provider network contract is for dental services provided to a beneficiary of the federal Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.) or the federal Medicaid program pursuant to Title XIX of the federal Social Security Act (42 U.S.C. Sec. 1396 et seq.).

(2) Access to a provider network contract is granted to a health insurer that issues, sells, renews, or offers a policy covering dental services or a contracting entity operating under the same brand licensee program as the contracting entity.

(3) Access to a provider network contract is granted to an affiliate of a contracting entity. A list of the contracting entity's affiliates shall be made available to a provider in writing or electronic form before access is granted to a third party pursuant to subdivision (b).

(f) The commissioner shall adopt regulations as are necessary to implement and enforce this section in accordance with the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(g) As used in this section:

(1) "Contracting entity" means a person or entity that enters into direct contracts with providers for the delivery of dental services in the ordinary course of business, including a health insurer or third-party administrator.

(2) "Dental services" means services for the diagnosis, prevention, treatment, or cure of a dental condition, illness, injury, or disease. "Dental services" does not include services delivered by a provider that are billed as medical expenses under a policy of health insurance.

(3) "Provider" means an individual or entity that provides dental services or supplies, as defined by the policy of health insurance or specialized policy of health insurance, including a dentist or physician, but not a physician organization that leases or rents its network to a third party.

(4) "Provider network contract" means a contract between a contracting entity and a provider entered into on or after January 1, 2020, that specifies the rights and responsibilities of the contracting entity and provides for the delivery and payment of dental services to an insured.

(5) "Third party" means a person or entity that enters into a contract with a contracting entity or with another third party to gain access to the dental services or contractual discounts of a provider network contract. "Third party" does not include an employer or other group for whom the health insurer or contracting entity provides administrative services, including the payment of claims.

(Added by Stats. 2019, Ch. 540, Sec. 2. (AB 954) Effective January 1, 2020.)

10120.41. (a) For purposes of this section, the following definitions shall apply:

(1) "Dental waiting period provision" means a health insurance policy provision that limits coverage for a specified period of time following an insured's effective date of coverage.

(2) "Health insurer" means an insurer that issues, sells, renews, or offers a policy of health insurance, as defined in subdivision (b) of Section 106, covering dental services, including a specialized health insurance policy covering dental services, as defined in subdivision (c) of Section 106.

(3) "Preexisting condition provision" means a policy provision that excludes or limits coverage for services, charges, or expenses incurred following an insured's effective date of coverage for a condition for which dental services, diagnosis, care, or treatment was recommended or received preceding the effective date of coverage.

(b) On and after January 1, 2025, a health insurer shall not issue, sell, renew, or offer a policy that imposes a dental waiting period provision in a large group dental insurance policy or preexisting condition provision upon an insured for any dental insurance policy.

(c) This section does not apply to Medi-Cal dental managed care contracts authorized under Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(Added by Stats. 2023, Ch. 557, Sec. 4. (AB 1048) Effective January 1, 2024.)

10120.42. (a) To assist a provider in determining if an insured's dental coverage is regulated by the State of California, the health insurer shall disclose whether the insured's dental coverage is "State Regulated" through a provider portal, if available, or otherwise upon request, on or after January 1, 2025.

(b) A health insurer shall include the statement "State Regulated" if the insured's dental coverage is subject to regulation by the department, on an electronic or physical identification card, or both if available, for policies covering dental services issued on or after January 1, 2025.

(c) For purposes of this section, "health insurer" means a health insurer that issues, sells, renews, or offers a policy covering dental services, including a specialized health insurer covering dental services.

(Added by Stats. 2023, Ch. 125, Sec. 2. (AB 952) Effective January 1, 2024.)

10120.5. Any act by a disability insurer that covers hospital, medical, or surgical expenses that violates Section 510, Section 2056, or Section 2056.1 of the Business and Professions Code shall also be a violation of this code.

(Added by Stats. 1996, Ch. 1094, Sec. 2. Effective January 1, 1997.)

10121. (a) No self-insured employee welfare benefit plan, issued or renewed on or after November 23, 1970, which contains coverage for sterilization operations or procedures, shall impose any disclaimer, restriction on, or limitation of, coverage relative to the covered individual's reason for sterilization. All those plans entered into or renewed on or after November 23, 1970, shall be construed to be in compliance with this section, and any provision in any plan which is in conflict with this section shall be of no force or effect.

(b) Every self-insured employee welfare benefit plan issued or amended on or after July 1, 1972, which provides benefits to the employee's dependents, shall contain a provision granting immediate accident and sickness coverage, from and after the moment of birth, to each newborn infant of any family covered and to each minor child placed for adoption from and after the moment the child is placed in the physical custody of the covered family for adoption. No plan may be issued or amended if it contains any disclaimer, waiver, or other limitation of coverage relative to the coverage or insurability of newborn infants of or minor children placed for adoption with a family covered as required by this section. Coverage of minor children placed for adoption with a covered family shall be required only after January 1, 1988.

(c) No self-insured employee welfare benefit plan which provides maternity benefits for a person covered continuously from conception shall be issued, amended, delivered, or renewed in this state on or after July 1, 1976, if it contains any exclusion, reduction, or other limitations as to coverage, deductibles, or coinsurance provisions as to involuntary complications of pregnancy, unless those provisions apply generally to all benefits paid under the plan. If a fixed amount is specified in the plan for surgery, the fixed amounts for surgical procedures involving involuntary complications of pregnancy shall be commensurate with other fixed amounts payable for procedures of comparable difficulty and severity. In a case where a fixed amount is payable for maternity benefits, involuntary complications of pregnancy shall be deemed an illness and entitled to benefits otherwise provided by the plan. Where the plan contains a maternity deductible, the maternity deductible shall apply only to expenses resulting from normal delivery and cesarean section delivery. However, expenses for cesarean section delivery in excess of the deductible shall be treated as expenses for any other illness under the plan. This subdivision shall apply to all self-insured employee welfare benefit plans except any plan made subject to an applicable collective bargaining agreement in effect before July 1, 1976.

For purposes of this subdivision, involuntary complications of pregnancy shall include, but not be limited to, puerperal infection, eclampsia, cesarean section delivery, ectopic pregnancy, and toxemia.

All plans subject to this subdivision and issued, amended, delivered, or renewed in this state on or after July 1, 1976, shall be construed to be in compliance with this section, and any provision in any plan which is in conflict with this section shall be of no force or effect.

(d) Every self-insured employee welfare benefit plan issued or amended on or after January 1, 1987, which provides benefits to the employee's dependents, shall offer a choice to all employees of coverage for comprehensive preventive health care for children.

(e) For purposes of this section, benefits for the comprehensive preventive care of children shall be consistent with the Guidelines for Health Supervision of Children and Youth, as adopted by the American Academy of Pediatrics in May 1982, and provide for the following:

(1) Physician service for routine physical examinations.

(2) Immunizations.

(3) Laboratory services in connection with routine physical examinations.

(f) As used in this section, "self-insured employee welfare benefit plan" means any plan or program of benefits provided by an employer or an employee organization, or both, for the purpose of providing hospital, medical, surgical, nursing, or dental services, or indemnification for the costs incurred for those services, to the employer's employees or their dependents.

(Amended by Stats. 1988, Ch. 160, Sec. 118.)

10121.5. (a) When spouses are both employed as employees, and both have enrolled themselves and their eligible family members under a group policy of disability insurance provided by their respective employers, and each spouse is covered as an employee under the terms of the same master policy, each spouse may claim on his or her behalf, or on behalf of his or her enrolled dependents, the combined maximum contractual benefits to which an employee is entitled under the terms of the master policy, not to exceed in the aggregate 100 percent of the charge for the covered expense or service.

(b) When spouses are both employed as employees, and both have enrolled themselves and their eligible family members under a self-insured employee welfare benefit plan provided by their respective employers, and each spouse is covered as an employee

under the terms of the same master contract, each spouse may claim on his or her behalf, or on behalf of his or her enrolled dependents, the combined maximum contractual benefits to which an employee is entitled under the terms of the master contract, not to exceed in the aggregate 100 percent of the charge for the covered expense or service.

(c) This section shall apply to every group disability insurance policy and self-insured employee welfare benefit plan which is entered into, issued, delivered, amended, or renewed in this state on or after January 1, 1978.

(Amended by Stats. 2016, Ch. 50, Sec. 58. (SB 1005) Effective January 1, 2017.)

10121.6. (a) No policy of group disability insurance or self-insured employee welfare benefit plan which provides hospital, medical, or surgical expense benefits for employees, insureds, or policyholders and their dependents shall exclude a dependent child from eligibility or benefits solely because the dependent child does not reside with the employee, insured, or policyholder.

(b) Each policy of group disability insurance or self-insured employee welfare benefit plan which provides hospital, medical, or surgical expense benefits for employees, insureds, or policyholders and their dependents shall enroll, upon application by the employer or group administrator, a dependent child of the noncustodial parent when that parent is the employee, insured, or policyholder at any time either the parent or the person having custody of the child as defined in Section 3751.5 of the Family Code, or the local child support agency makes an application for enrollment to the employer or group administrator when a court order for medical support exists. In the case of children who are eligible for medicaid, the State Department of Health Services may also make that application.

(Amended by Stats. 2000, Ch. 808, Sec. 109. Effective September 28, 2000.)

10121.7. (a) A policy of group health insurance that provides hospital, medical, or surgical expense benefits shall provide equal coverage to employers or guaranteed associations, as defined in Section 10700, for the registered domestic partner of an employee, insured, or policyholder to the same extent, and subject to the same terms and conditions, as provided to a spouse of the employee, insured, or policyholder, and shall inform employers and guaranteed associations of this coverage. A policy shall not offer or provide coverage for a registered domestic partner that is not equal to the coverage provided to the spouse of an employee, insured, or policyholder, and shall not discriminate in coverage between spouses or domestic partners of a different sex and spouses or domestic partners of the same sex. The prohibitions and requirements imposed by this section are in addition to any other prohibitions and requirements imposed by law.

(b) If an employer or guaranteed association has purchased coverage for spouses and registered domestic partners pursuant to subdivision (a), a health insurer that provides hospital, medical, or surgical expense benefits for employees, insureds, or policyholders and their spouses shall enroll, upon application by the employer or group administrator, a registered domestic partner of the employee, insured, or policyholder in accordance with the terms and conditions of the group contract that apply generally to all spouses under the policy, including coordination of benefits.

(c) For purposes of this section, the term “domestic partner” shall have the same meaning as that term is used in Section 297 of the Family Code.

(d) (1) A policy of group health insurance may require that the employee, insured, or policyholder verify the status of the domestic partnership by providing to the insurer a copy of a valid Declaration of Domestic Partnership filed with the Secretary of State pursuant to Section 298 of the Family Code or an equivalent document issued by a local agency of this state, another state, or a local agency of another state under which the partnership was created. The policy may also require that the employee, insured, or policyholder notify the insurer upon the termination of the domestic partnership.

(2) Notwithstanding paragraph (1), a policy may require the information described in that paragraph only if it also requests from the employee, insured, or policyholder whose spouse is provided coverage, verification of marital status and notification of dissolution of the marriage.

(e) Nothing in this section shall be construed to expand the requirements of Section 4980B of Title 26 of the United States Code, Section 1161, and following, of Title 29 of the United States Code, or Section 300bb-1, and following, of Title 42 of the United States Code, as added by the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99-272), and as those provisions may be later amended.

(f) A group health insurance policy subject to this section that is issued, amended, delivered, or renewed in this state on or after January 2, 2005, shall be deemed to provide coverage for registered domestic partners that is equal to the coverage provided to a spouse of an employee, insured, or policyholder.

(Amended by Stats. 2011, Ch. 722, Sec. 4. (SB 757) Effective January 1, 2012.)

10122. If a policy of group disability insurance issued or issued for delivery or amended in this state after the effective date of this section provides in any manner for coverage for an employee and one or more covered persons dependent upon such employee and provides for an extension of coverage for any period following a termination of employment of the employee, the policy shall provide that such extension of coverage shall apply to dependents upon the same terms and conditions precedent as applied to the

covered employee, for the same period of time, subject to payment of premiums, if any, as required by the terms of the policy and subject to any applicable collective bargaining agreement.

All such group disability policies issued or issued for delivery or amended in this state after the effective date of this section shall be automatically construed to be in compliance with this section and need not be refiled or reprinted.

(Amended by Stats. 1972, Ch. 40.)

10122.1. On and after the effective date of this section, every policy of disability insurance which covers hospital, medical, or surgical expenses on a group basis shall offer coverage to physically handicapped individual members of the group under the same terms and conditions as are normally offered to individual members of the group without physical handicap. The availability of such coverage shall be communicated to group policyholders and to prospective group policyholders during negotiations. Group policies shall not be required to cover hospital, medical, or surgical expenses arising as a direct result of an individual member's physical handicap.

(Added by renumbering Section 10123.1 (as added by Stats. 1974, Ch. 964) by Stats. 1980, Ch. 676, Sec. 188.)

10122.2. If a policy of group disability insurance issued, delivered, amended, or renewed in this state on or after the effective date of this section provides in any manner for coverage for an employee and a covered spouse dependent upon such employee, the policy shall not provide for coverage under conditions less favorable for employees than coverage provided for covered spouses dependent upon the employees.

(Added by Stats. 1976, Ch. 59.)

10123. (a) No self-insured employee welfare benefit plan, issued or renewed on or after the effective date of this section, which provides coverage for an employee and one or more covered persons dependent upon such employee and provides for an extension of coverage for any period following a termination of employment of the employee, shall fail to provide that such extension of coverage shall apply to dependents upon the same terms and conditions precedent as applied to the covered employee, for the same period of time, subject to payment of premiums, if any, as required by the terms of the policy and subject to any limitations or conditions set forth in any applicable collective-bargaining agreement. All such plans entered into or renewed on or after the effective date of this section shall be construed to be in compliance with this section, and any provision in any such plan which is in conflict with this section shall be of no force or effect.

(b) A plan contract which provides benefits that accrue after a certain time of confinement in a health care facility shall specify what constitutes a day of confinement or the number of consecutive hours of confinement which are requisite to the commencement of benefits.

(c) As used in subdivisions (a) and (b), "self-insured employee welfare benefit plan" has the same meaning as that specified in subdivision (d) of Section 10121.

(Amended by Stats. 1978, Ch. 648.)

10123.1. Every self-insured employee welfare benefit plan, as defined in Section 10121, issued, amended as to benefits, or renewed after January 1, 1977, shall comply with the requirements of Article 1.5 (commencing with Section 10128) of this chapter.

(Amended by Stats. 1977, Ch. 64.)

10123.2. On and after the effective date of this section, every self-insured employee welfare benefit plan which provides coverage for hospital, medical, or surgical expenses shall offer coverage to physically handicapped persons for such expenses incurred, under such terms and conditions as are normally provided by the self-insured welfare benefit plan and a member without physical handicap. Every self-insured welfare benefit plan shall communicate the availability of such coverage to all members and prospective members. The self-insured welfare benefit plan shall not be required to cover hospital, medical, or surgical expenses arising as a direct result of a physically disabled person's handicap.

(Added by Stats. 1974, Ch. 964.)

10123.3. (a) No self-insured employee welfare benefit plan shall refuse to enroll any person or accept any person as a subscriber or renew any person as a subscriber after appropriate application on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring. No plan shall require a higher rate or charge, or offer or provide different terms, conditions, or benefits, on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring than is at the time required of any other individual in an otherwise identical classification, nor shall any plan make or require any rebate, discrimination, or discount upon the amount to be paid or the service to be rendered under the plan because the person carries those traits.

(b) No self-insured employee welfare benefit plan shall seek information about a person's genetic characteristics for any nontherapeutic purpose.

(c) No discrimination shall be made in the fees or commissions of a solicitor or solicitor firm for an enrollment or a subscription or the renewal of an enrollment or subscription of any person on the basis of a person's genetic characteristics that may, under some circumstances, be associated with disability in that person or that person's offspring.

(d) "Genetic characteristics" as used in this section means either of the following:

(1) Any scientifically or medically identifiable gene or chromosome, or combination or alteration thereof, that is known to be a cause of a disease or disorder in a person or his or her offspring, or that is determined to be associated with a statistically increased risk of development of a disease or disorder, and that is presently not associated with any symptoms of any disease or disorder.

(2) Inherited characteristics that may derive from the individual or family member, that are known to be a cause of a disease or disorder in a person or his or her offspring, or that are determined to be associated with a statistically increased risk of development of a disease or disorder, and that are presently not associated with any symptoms of any disease or disorder.

(Amended by Stats. 1999, Ch. 311, Sec. 4. Effective January 1, 2000.)

10123.31. (a) In addition to any other remedy permitted by law, the commissioner shall have the administrative authority to assess penalties specified in this section against self-insured employee welfare benefit plans engaged in the business of health insurance for violations of Section 10123.3.

(b) Any plan that violates Section 10123.3 is liable for administrative penalties of not more than two thousand five hundred dollars ($2,500) for the first violation and not more than five thousand dollars ($5,000) for each subsequent violation.

(c) Any plan that violates Section 10123.3 with a frequency that indicates a general business practice or commits a knowing violation of that section, is liable for administrative penalties of not less than fifteen thousand dollars ($15,000) and not more than one hundred thousand dollars ($100,000) for each violation.

(d) An act or omission that is inadvertent and that results in incorrect rates being charged to more than one subscriber shall be a single violation for the purpose of this section.

(Added by Stats. 1995, Ch. 695, Sec. 5. Effective January 1, 1996.)

10123.35. (a) This section shall apply to the disclosure of genetic test results contained in an applicant or enrollee's medical records by a self-insured welfare benefit plan.

(b) Any person who negligently discloses results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not to exceed one thousand dollars ($1,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(c) Any person who willfully discloses the results of a test for a genetic characteristic to any third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), shall be assessed a civil penalty in an amount not less than one thousand dollars ($1,000) and no more than five thousand dollars ($5,000) plus court costs, as determined by the court, which penalty and costs shall be paid to the subject of the test.

(d) Any person who willfully or negligently discloses the results of a test for a genetic characteristic to a third party in a manner that identifies or provides identifying characteristics of the person to whom the test results apply, except pursuant to a written authorization as described in subdivision (g), that results in economic, bodily, or emotional harm to the subject of the test, is guilty of a misdemeanor punishable by a fine not to exceed ten thousand dollars ($10,000).

(e) In addition to the penalties listed in subdivisions (b) and (c), any person who commits any act described in subdivision (b) or (c) shall be liable to the subject for all actual damages, including damages for economic, bodily, or emotional harm which is proximately caused by the act.

(f) Each disclosure made in violation of this section is a separate and actionable offense.

(g) The applicant's "written authorization," as used in this section, shall satisfy the following requirements:

(1) Is written in plain language.

(2) Is dated and signed by the individual or a person authorized to act on behalf of the individual.

(3) Specifies the types of persons authorized to disclose information about the individual.

(4) Specifies the nature of the information authorized to be disclosed.

(5) States the name or functions of the persons or entities authorized to receive the information.

(6) Specifies the purposes for which the information is collected.

(7) Specifies the length of time the authorization shall remain valid.

(8) Advises the person signing the authorization of the right to receive a copy of the authorization. Written authorization is required for each separate disclosure of the test results, and the authorization shall set forth the person or entity to whom the disclosure would be made.

(h) This section shall not apply to disclosures required by the Department of Health Services necessary to monitor compliance with Chapter 1 (commencing with Section 124975) of Part 5 of Division 106 of the Health and Safety Code, nor to disclosures required by the Department of Managed Health Care necessary to administer and enforce compliance with Section 1374.7 of the Health and Safety Code.

(Amended by Stats. 2000, Ch. 857, Sec. 59. Effective January 1, 2001.)

10123.36. (a) On or before July 1, 1999, for purposes of public disclosure, every disability insurer that covers hospital, medical, or surgical expenses, and authorizes insureds to select providers who have contracted with the insurer for alternative rates of payment as described in Section 10133, and the disability insurer or any of its contracting providers or provider groups utilize economic profiling related to services provided to insureds, shall file with the department a description of any policies and procedures related to economic profiling utilized by the insurer and any of its contracting providers and provider groups. The filing shall describe how these policies and procedures are used in utilization review, peer review, incentive and penalty programs, and in provider retention and termination decisions. The filing shall also indicate in what manner, if any, the economic profiling system being used takes into consideration risk adjustments that reflect case mix, type and severity of patient illness, age of patients, and other policyholder characteristics that may account for higher or lower than expected costs or utilization of services. Any changes to the policies and procedures shall be filed expeditiously with the commissioner. Nothing in this section shall be construed to restrict or impair the department, in its discretion, from utilizing the information filed pursuant to this section for purposes of ensuring compliance with this chapter.

(b) The commissioner shall make each disability insurer filing available to the public upon request. The commissioner shall not publicly disclose any information submitted pursuant to this section that is determined by the commissioner to be confidential pursuant to state law.

(c) Each disability insurer that uses economic profiling shall, upon request, provide a copy of economic profiling information related to a contracting provider or provider group to the profiled provider or group. In addition, each disability insurer shall require as a condition of contract that its contracting provider groups that maintain economic profiles of individual providers who may be selected by insureds shall, upon request, provide a copy of individual economic profiling information to individual providers who are profiled. The economic profiling information provided pursuant to this section shall be provided upon request until 60 days after the date upon which the contract between the insurer and the individual provider or provider group terminates, or until 60 days after the date the contract between the provider group and the individual provider terminates, whichever is applicable.

(d) For the purposes of this section, “economic profiling” shall mean any evaluation of a particular physician, provider, or provider group based in whole or in part on the economic costs or utilization of services associated with medical care provided or authorized by the physician, provider, or provider group.

(Added by Stats. 1998, Ch. 893, Sec. 2. Effective January 1, 1999.)

10123.38. (a) A health insurance policy issued, amended, or renewed on or after January 1, 2025, shall provide coverage for the prophylaxis, diagnosis, and treatment of Pediatric Autoimmune Neuropsychiatric Disorder Associated with Streptococcal Infections (PANDAS) and Pediatric Acute-onset Neuropsychiatric Syndrome (PANS) that is prescribed or ordered by the treating physician and surgeon and is medically necessary, as defined by current nationally recognized clinical practice guidelines by expert treating physicians published in peer-reviewed medical literature. Treatment for PANDAS and PANS that shall be covered includes antibiotics, medication and behavioral therapies to manage neuropsychiatric symptoms, immunomodulating medicines, plasma exchange, and intravenous immunoglobulin therapy.

(b) Coverage for PANDAS and PANS shall not be subject to a copayment, coinsurance, deductible, or other cost sharing that is greater than that applied to other benefits provided by the policy.

(c) (1) A required authorization for PANDAS and PANS prophylaxis, diagnosis, or treatment shall be provided in a timely manner that is appropriate for the severity of an insured’s condition pursuant to Section 10133.54.

(2) A health insurer shall not deny or delay coverage for PANDAS or PANS therapies because the insured previously received treatment, including the same or similar treatment, for PANDAS or PANS, or because the insured was diagnosed with or received

treatment for their condition under a different diagnostic name, including autoimmune encephalopathy.

(3) A health insurer shall not limit coverage of immunomodulating therapies for PANDAS or PANS in a manner that is inconsistent with the treatment recommendations pursuant to subdivision (d), and shall not require a trial of therapies that treat only neuropsychiatric symptoms before authorizing coverage of immunomodulating therapies pursuant to this section.

(d) Coverage for PANDAS and PANS shall adhere to the treatment recommendations delineated in current clinical practice guidelines published in peer-reviewed medical literature or put forth by organizations composed of expert treating clinicians.

(e) For billing and diagnostic purposes, PANDAS and PANS shall be coded as autoimmune encephalitis until the American Medical Association and the federal Centers for Medicare and Medicaid Services create and assign a specific code or codes for PANDAS and PANS. After the creation of that code or codes, PANDAS and PANS may be coded as autoimmune encephalitis, PANDAS, or PANS. If PANDAS or PANS is known by a different common name in the future, it may be coded under that name and this section shall apply to that disorder or syndrome.

(f) This section does not apply to a specialized health insurance policy that covers dental or vision benefits or a Medicare supplement policy.

(Added by Stats. 2024, Ch. 822, Sec. 2. (AB 2105) Effective January 1, 2025.)

10123.4. If a self-insured employee welfare benefit plan issued, amended, or renewed in this state on or after the effective date of this section provides in any manner for coverage for an employee and a covered spouse dependent upon such employee, the plan shall not provide for coverage under conditions less favorable for employees than coverage provided for covered spouses dependent upon the employees.

As used in this section, “self-insured employee welfare benefit plan” has the same meaning as that specified in subdivision (b) of Section 10121.

(Added by Stats. 1976, Ch. 59.)

10123.5. (a) On or after January 1, 1993, every insurer issuing group disability insurance that covers hospital, medical, or surgical expenses shall provide benefits for the comprehensive preventive care of children 16 years of age or younger under those terms and conditions as may be agreed upon between the group policyholder and the insurer. Every insurer shall communicate the availability of these benefits to all group policyholders and to all prospective group policyholders with whom they are negotiating.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The most recent Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics.

(B) The most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians, unless the State Department of Public Health determines, within 45 days of the published date of the schedule, that the schedule is not consistent with the purposes of this section.

(2) Provide for the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

(D) Screening for blood lead levels in children who are at risk for lead poisoning, as determined by a health care provider in accordance with the applicable California regulations.

(c) For purposes of this section, a health care provider is any of the following:

(1) A person licensed to practice medicine pursuant to Article 3 (commencing with Section 2050) of Chapter 5 of Division 2 of the Business and Professions Code.

(2) A nurse practitioner licensed to practice pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.

(3) A physician assistant licensed to practice pursuant to Article 3 (commencing with Section 3513) of Chapter 7.7 of Division 2 of the Business and Professions Code.

(Amended by Stats. 2017, Ch. 507, Sec. 10. (AB 1316) Effective January 1, 2018.)

10123.51. (a) A health insurance policy issued, amended, or renewed on or after January 1, 2022, that provides coverage for pediatric services and preventive care, as required by this chapter, including Sections 10112.2 and 10112.27, shall additionally include coverage for adverse childhood experiences screenings. This section does not prohibit a health insurer from applying cost-sharing requirements as authorized by law.

(b) For purposes of this section, "adverse childhood experiences," or "ACEs," means an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or threatening and that has lasting adverse effects on the individual's functioning and physical, social, emotional, or spiritual well-being.

(c) The department may adopt guidance to health insurers to implement this section. The guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The departmental guidance shall apply the rules and regulations for screening for trauma as set forth in the Medi-Cal program as the minimum ACEs coverage requirements for health insurers. This section does not prohibit a health insurer from exceeding the Medi-Cal program's rules and regulations for trauma screening.

(Added by Stats. 2021, Ch. 641, Sec. 2. (SB 428) Effective January 1, 2022.)

10123.55. (a) On or after January 1, 1993, every insurer issuing group disability insurance that covers hospital, medical, or surgical expenses shall offer benefits for the comprehensive preventive care of children 17 and 18 years of age under those terms and conditions as may be agreed upon between the group policyholder and the insurer. Every insurer shall communicate the availability of these benefits to all group policyholders and to all prospective group policyholders with whom they are negotiating.

(b) For purposes of this section, benefits for the comprehensive preventive care of children shall comply with both of the following:

(1) Be consistent with both of the following:

(A) The most recent Recommendations for Preventive Pediatric Health Care, as adopted by the American Academy of Pediatrics.

(B) The most current version of the Recommended Childhood Immunization Schedule/United States, jointly adopted by the American Academy of Pediatrics, the Advisory Committee on Immunization Practices, and the American Academy of Family Physicians, unless the State Department of Public Health determines, within 45 days of the published date of the schedule, that the schedule is not consistent with the purposes of this section.

(2) Provide for the following:

(A) Periodic health evaluations.

(B) Immunizations.

(C) Laboratory services in connection with periodic health evaluations.

(D) Screening for blood lead levels in children who are at risk for lead poisoning, as determined by a health care provider in accordance with the applicable California regulations.

(c) For purposes of this section, a health care provider is any of the following:

(1) A person licensed to practice medicine pursuant to Article 3 (commencing with Section 2050) of Chapter 5 of Division 2 of the Business and Professions Code.

(2) A nurse practitioner licensed to practice pursuant to Article 8 (commencing with Section 2834) of Chapter 6 of Division 2 of the Business and Professions Code.

(3) A physician assistant licensed to practice pursuant to Article 3 (commencing with Section 3513) of Chapter 7.7 of Division 2 of the Business and Professions Code.

(Amended by Stats. 2017, Ch. 507, Sec. 11. (AB 1316) Effective January 1, 2018.)

10123.6. On and after January 1, 1990, every insurer issuing group disability insurance which covers hospital, medical, or surgical expenses shall offer coverage for the treatment of alcoholism under such terms and conditions as may be agreed upon between the group policyholder and the insurer. Every insurer shall communicate the availability of such coverage to all group policyholders and to all prospective group policyholders with whom they are negotiating.

If the group subscriber or policyholder agrees to such coverage or to coverage for treatment of chemical dependency, or nicotine use, the treatment may take place in facilities licensed to provide alcoholism or chemical dependency services under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

Treatment for nicotine use may be subject to separate deductibles, copayments, and overall cost limitations as determined by the policy.

(Amended by Stats. 1989, Ch. 688, Sec. 2.)

10123.61. (a) Commencing January 1, 2019, a health insurer shall not issue, amend, sell, renew, or offer a policy of short-term limited duration health insurance in this state.

(b) For purposes of this section, “short-term limited duration health insurance” means health insurance coverage provided pursuant to a health insurance policy that has an expiration date specified in the policy that is less than 12 months after the original effective date of the coverage.

(Added by Stats. 2018, Ch. 687, Sec. 4. (SB 910) Effective January 1, 2019.)

10123.65. (a) The maximum amount a health insurer may require an insured to pay at the point of sale for a covered prescription drug is the lesser of the following:

(1) The applicable cost-sharing amount for the prescription drug.

(2) The retail price.

(b) A health insurer shall not require a pharmacist or pharmacy to charge or collect from an insured a cost-sharing amount that exceeds the total retail price for the prescription drug.

(c) The payment rendered shall constitute the applicable cost sharing and shall apply to the deductible, if any, and also to the maximum out-of-pocket limit in the same manner as if the insured had purchased the prescription drug by paying the cost-sharing amount.

(Added by Stats. 2018, Ch. 770, Sec. 3. (AB 2863) Effective January 1, 2019.)

10123.67. (a) On or before July 1, 1997, every disability insurer that covers hospital, medical, or surgical expenses, as described in subdivision (b), shall file with the department a written policy, which is not subject to approval or disapproval by the department, describing the manner in which the insurer determines if a second medical opinion is medically necessary and appropriate. Notice of the policy and information regarding the manner in which an insured may receive a second medical opinion shall be provided to all insureds in the insurer’s evidence of coverage. The written policy shall describe the manner in which requests for a second medical opinion are reviewed by the insurer.

(b) This section shall only apply to disability insurers covering hospital, medical, or surgical expenses that contract with providers for alternative rates pursuant to Section 10133 or 11512 and that limit payments under those policies to services secured by insureds from providers charging alternative rates pursuant to the contracts.

(c) Nothing in this section shall require the disability insurer to cover services or provide benefits that are not otherwise covered under the terms and conditions of the plan contract, nor to provide services through providers who are not under contract with the plan.

(Added by Stats. 1996, Ch. 1091, Sec. 2. Effective January 1, 1997.)

10123.68. (a) When requested by an insured or contracting health professional who is treating an insured, a disability insurer that covers hospital, medical, or surgical expenses shall authorize a second opinion by an appropriately qualified health care professional. Reasons for a second opinion to be provided or authorized shall include, but are not limited to, the following:

(1) If the insured questions the reasonableness or necessity of recommended surgical procedures.

(2) If the insured questions a diagnosis or plan of care for a condition that threatens loss of life, loss of limb, loss of bodily function, or substantial impairment, including, but not limited to, a serious chronic condition.

(3) If clinical indications are not clear or are complex and confusing, a diagnosis is in doubt due to conflicting test results, or the treating health professional is unable to diagnose the condition and the insured requests an additional diagnosis.

(4) If the treatment plan in progress is not improving the medical condition of the insured within an appropriate period of time given the diagnosis and plan of care, and the insured requests a second opinion regarding the diagnosis or continuance of the treatment.

(5) If the insured has attempted to follow the plan of care or consulted with the initial provider concerning serious concerns about the diagnosis or plan of care.

(b) For purposes of this section, an appropriately qualified health care professional is a primary care physician or a specialist who is acting within his or her scope of practice and who possesses a clinical background, including training and expertise, related to the particular illness, disease, condition or conditions associated with the request for a second opinion.

(c) If an insured or participating health professional who is treating an insured requests a second opinion pursuant to this section, an authorization or denial shall be provided in an expeditious manner. When the insured's condition is such that the insured faces an imminent and serious threat to his or her health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or lack of timeliness that would be detrimental to the insured's life or health or could jeopardize the insured's ability to regain maximum function, the second opinion shall be rendered in a timely fashion appropriate to the nature of the insured's condition, not to exceed 72 hours after the insurer's receipt of the request, whenever possible. Each insurer shall file with the Department of Insurance timelines for responding to requests for second opinions for cases involving emergency needs, urgent care, and other requests by July 1, 2000, and within 30 days of any amendment to the timelines. The timelines shall be made available to the public upon request.

(d) If an insurer approves a request by an insured for a second opinion, the insured shall be responsible only for the costs of applicable copayments that the insurer requires for similar referrals.

(e) If the insured is requesting a second opinion about care from his or her primary care physician, the second opinion shall be provided by an appropriately qualified health care professional of the insured's choice who is contracted with the insurer.

(f) If the insured is requesting a second opinion about care from a specialist, the second opinion shall be provided by any provider of the same or equivalent specialty, of the insured's choice, within the insurer's provider network, if the insurance contract limits second opinions to within a network.

(g) The insurer may limit second opinions to its network of providers if the insurance contract limits the benefit to within a network of providers and there is a participating provider who meets the standard specified in subdivision (b). If there is no participating provider who meets this standard, then the insurer shall authorize a second opinion by an appropriately qualified health professional outside of the insurer's provider network. In approving a second opinion either inside or outside of the insurer's provider network, the insurer shall take into account the ability of the insured to travel to the provider.

(h) The insurer shall require the second opinion health professional to provide the insured and the initial health professional with a consultation report, including any recommended procedures or tests that the second opinion health professional believes appropriate. Nothing in this section shall be construed to prevent the insurer from authorizing, based on its independent determination, additional medical opinions concerning the medical condition of an insured.

(i) If the insurer denies a request by an insured for a second opinion, it shall notify the insured in writing of the reasons for the denial and shall inform the insured of the right to dispute the denial, and the procedures for exercising that right.

(j) If the insurance contract limits health care services to within a network of providers, in order for coverage to be in force, the insured shall obtain services only from a provider who is participating in, or under contract with, the insurer pursuant to the specific insurance contract under which the insured is entitled to health care service benefits.

(k) This section shall not apply to any policy or contract of disability insurance that covers hospital, medical, or surgical expenses and that does not limit second opinions, subject to all other terms and conditions of the contract.

(l) This section shall not apply to accident-only, specified disease, or hospital indemnity health insurance policies.

(Amended by Stats. 2000, Ch. 135, Sec. 113. Effective January 1, 2001. Note: Amendment by Stats. 2000, Ch. 857, was nullified because of Ch. 857's prevailing deferral clause.)

10123.7. (a) On or after January 1, 1986, an insurer issuing group health insurance shall offer coverage for orthotic and prosthetic devices and services under the terms and conditions that may be agreed upon between the group policyholder and the insurer. An insurer shall communicate the availability of that coverage to all group policyholders and to all prospective group policyholders with whom the insurer is negotiating. Coverage for prosthetic devices shall include original and replacement devices, as prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license. Coverage for orthotic devices shall provide for coverage if the device, including original and replacement devices, is prescribed by a physician and surgeon or doctor of podiatric medicine acting within the scope of his or her license, or is ordered by a licensed health care provider acting within the scope of his or her license. An insurer shall have the right to conduct a utilization review to determine medical necessity before authorizing these services.

(b) Notwithstanding subdivision (a), on and after July 1, 2007, the amount of the benefit for orthotic and prosthetic devices and services shall be no less than the annual and lifetime benefit maximums applicable to all benefits in the policy. A copayment, coinsurance, deductible, and maximum out-of-pocket amount applied to the benefit for orthotic and prosthetic devices and services shall be no more than the most common amounts contained in the policy.

(c) This section shall not apply to Medicare supplement, vision-only, dental-only, or CHAMPUS supplement insurance, or to hospital indemnity, hospital-only, accident-only, or specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(Amended by Stats. 2018, Ch. 687, Sec. 5. (SB 910) Effective January 1, 2019.)

10123.8. (a) Every policy of disability insurance that provides coverage for hospital, medical, or surgical expenses, that is issued, amended, delivered, or renewed on or after January 1, 2000, shall provide coverage for screening for, diagnosis of, and treatment for, breast cancer.

(b) No policy of disability insurance that provides coverage for hospital, medical, or surgical expenses shall deny enrollment or coverage to an individual solely due to a family history of breast cancer, or who has had one or more diagnostic procedures for breast disease but has not developed or been diagnosed with breast cancer.

(c) Every policy of disability insurance shall cover screening and diagnosis of breast cancer, consistent with generally accepted medical practice and scientific evidence, upon the referral of the insured's participating physician.

(d) Treatment for breast cancer under this section shall include coverage for prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applied to the mastectomy and all other terms and conditions applicable to other benefits.

(e) As used in this section, "mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon. Partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of the tumor with clear margins.

(f) As used in this section, "prosthetic devices" means the provision of initial and subsequent devices pursuant to an order of the patient's physician and surgeon.

(g) For purposes of this section, disability insurance does not include accident only, credit, disability income, specified disease and hospital confinement indemnity, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement, long-term care insurance, dental, vision, 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.

(Amended by Stats. 2012, Ch. 449, Sec. 4. (SB 255) Effective January 1, 2013.)

10123.81. (a) An individual or group policy of disability insurance or self-insured employee welfare benefit plan shall be deemed to provide coverage for mammography for screening or diagnostic purposes upon the referral of a participating nurse practitioner, participating certified nurse-midwife, participating physician assistant, or participating physician, providing care to the patient and operating within the scope of practice provided under existing law.

(b) This section does not prevent the application of copayment or deductible provisions in a policy, nor does this section require that a policy be extended to cover any other procedures under an individual or a group policy. This section does not authorize a policyholder to receive the services required to be covered by this section if those services are furnished by a nonparticipating provider, unless the policyholder is referred to that provider by a participating physician, nurse practitioner, or certified nurse-midwife providing care.

(c) This section shall not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance.

(Amended by Stats. 2018, Ch. 687, Sec. 6. (SB 910) Effective January 1, 2019.)

10123.82. Every policy of disability insurance which provides for the surgical procedure known as a laryngectomy and which is issued, amended, delivered, or renewed in this state on or after January 1, 1993, shall include coverage for prosthetic devices to restore a method of speaking for the patient incident to the laryngectomy.

Coverage for prosthetic devices shall be subject to the deductible and coinsurance conditions applied to the laryngectomy, and all other terms and conditions applicable to other benefits. As used in this section, "laryngectomy" means the removal of the larynx for medically necessary reasons, as determined by a licensed physician and surgeon.

Any provision in any policy issued, amended, delivered, or renewed in this state on or after January 1, 1993, which is in conflict with this section shall be of no force or effect.

As used in this section, “prosthetic devices” means and includes the provision of initial and subsequent prosthetic devices, including installation accessories, pursuant to an order of the patient’s physician and surgeon. “Prosthetic devices” does not include electronic voice producing machines.

(Added by Stats. 1992, Ch. 808, Sec. 2. Effective January 1, 1993.)

10123.83. (a) On or after January 1, 1995, every policy of disability insurance that covers hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed in this state shall include obstetrician-gynecologists as eligible primary care physicians provided they meet the insurer’s written eligibility criteria for all specialists seeking primary care physician status.

(b) For purposes of this section, the term “primary care physician” means a physician, as defined in Section 14254 of the Welfare and Institutions Code, who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, and for initiating referral for specialist care. This means providing care for the majority of health care problems, including, but not limited to, preventive services, acute and chronic conditions, and psychosocial issues.

(Amended by Stats. 1995, Ch. 353, Sec. 1. Effective January 1, 1996.)

10123.835. (a) Every individual or group policy of disability insurance that covers hospital, medical, or surgical benefits that is issued, amended, or renewed on or after January 1, 1999, shall be deemed to provide coverage for the screening and diagnosis of prostate cancer, including, but not limited to, prostate-specific antigen testing and digital rectal examinations, when medically necessary and consistent with good professional practice.

(b) Nothing in this section shall be construed to require an individual or group policy to cover the surgical and other procedures known as radical prostatectomy, external beam radiation therapy, radiation seed implants, and combined hormonal therapy, or to prevent application of deductible or copayment provisions contained in the policy, nor shall this section be construed to require that coverage under an individual or group policy be extended to any other procedures.

(c) This section shall not apply to specified accident, specified disease, hospital indemnity, Medicare supplement, or long-term care health insurance policies.

(Added by renumbering Section 10123.83 (as added by Stats. 1998, Ch. 839) by Stats. 2009, Ch. 234, Sec. 11. (AB 299) Effective January 1, 2010.)

10123.84. (a) The Legislature finds and declares that the unique, private, and personal relationship between women patients and their obstetricians and gynecologists warrants direct access to obstetrical and gynecological physician services.

(b) Each policy of disability insurance that covers hospital, medical, or surgical expenses, and that is issued, amended, delivered, or renewed in this state, shall allow a policyholder the option to seek obstetrical and gynecological physician services directly from an obstetrician and gynecologist or directly from a participating family physician and surgeon designated by the plan as providing obstetrical and gynecological services.

(c) In implementing this section, a disability insurer may establish reasonable requirements governing utilization protocols and the use of obstetricians and gynecologists or family physicians and surgeons, as provided for in subdivision (b), if those requirements are consistent with the intent of this section, are customarily applied to other physicians and surgeons, including primary care physicians and surgeons, to whom the policyholder has direct access, and are no more restrictive for the provision of obstetrical and gynecological physician services. A policyholder shall not be required to obtain prior approval from another physician, another provider, or the insurer prior to obtaining direct access to obstetrical and gynecological physician services, but the insurer may establish reasonable requirements for the participating obstetrician and gynecologist or the family physician and surgeon, as provided in subdivision (b), to communicate with the policyholder’s primary care physician regarding the policyholder’s condition, treatment, and any need for followup care.

(d) This section does not diminish the requirements of Section 10123.83.

(Amended by Stats. 2019, Ch. 632, Sec. 13. (AB 1622) Effective January 1, 2020.)

10123.85. (a) For purposes of this section, the definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply.

(b) It is the intent of the Legislature to recognize the practice of telehealth as a legitimate means by which an individual may receive health care services from a health care provider without in-person contact with the health care provider.

(c) A health insurer shall not require that in-person contact occur between a health care provider and a patient before payment is made for the services appropriately provided through telehealth, subject to the terms and conditions of the contract entered into between the policyholder or contractholder and the insurer, and between the insurer and its participating providers or provider groups, and pursuant to Section 10123.855.

(d) A health insurer shall not limit the type of setting where services are provided for the patient or by the health care provider before payment is made for the covered services appropriately provided by telehealth, subject to the terms and conditions of the contract

between the policyholder or contractholder and the insurer, and between the insurer and its participating providers or provider groups, and pursuant to Section 10123.855.

(e) Notwithstanding any other law, this section does not authorize a health insurer to require the use of telehealth if the health care provider has determined that it is not appropriate.

(Amended by Stats. 2019, Ch. 867, Sec. 4. (AB 744) Effective January 1, 2020.)

10123.855. (a) (1) A contract between a health insurer and a health care provider for an alternative rate of payment pursuant to Section 10133 shall specify that the health insurer shall reimburse the treating or consulting health care provider for the diagnosis, consultation, or treatment of an insured or policyholder appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for reimbursement for the same service through in-person diagnosis, consultation, or treatment.

(2) This section does not limit the ability of a health insurer and a health care provider to negotiate the rate of reimbursement for a health care service provided pursuant to a contract subject to this section. Services that are the same, as determined by the provider's description of the service on the claim, shall be reimbursed at the same rate whether provided in person or through telehealth. When negotiating a rate of reimbursement for telehealth services for which no in-person equivalent exists, a health insurer and the provider shall ensure the rate is consistent with subdivision (a) of Section 10123.137.

(b) (1) A policy of health insurance that provides benefits through contracts with providers at alternative rates of payment shall specify that the health insurer shall provide coverage for health care services appropriately delivered through telehealth services on the same basis and to the same extent that the health insurer is responsible for coverage for the same service through in-person diagnosis, consultation, or treatment. Coverage shall not be limited only to services delivered by select third-party corporate telehealth providers.

(2) This section does not alter the existing statutory or regulatory obligations of a health insurer to ensure that insureds have access to all covered services through an adequate network of contracted providers, as required by Sections 10133 and 10133.5 and the regulations promulgated thereunder.

(3) This section does not require a health insurer to deliver health care services through telehealth services.

(4) This section does not require a health insurer to cover telehealth services provided by an out-of-network provider, unless coverage is required under other provisions of law.

(c) A health insurer may offer a policy containing a copayment or coinsurance requirement for a health care service delivered through telehealth services, provided that the copayment or coinsurance does not exceed the copayment or coinsurance applicable if the same services were delivered through in-person diagnosis, consultation, or treatment. This subdivision does not require cost sharing for services provided through telehealth.

(d) Services provided through telehealth and covered pursuant to this chapter shall be subject to the same deductible and annual or lifetime dollar maximum as equivalent services that are not provided through telehealth.

(e) The definitions in subdivision (a) of Section 2290.5 of the Business and Professions Code apply to this section.

(f) The provisions of this section are severable. If any provision of this section or its application is held invalid, that invalidity shall not affect other provisions or applications that can be given effect without the invalid provision or application.

(Amended by Stats. 2021, Ch. 439, Sec. 6. (AB 457) Effective January 1, 2022.)

10123.856. (a) If a health insurer offers a service via telehealth to an insured through a third-party corporate telehealth provider, all of the following conditions shall be met:

(1) The health insurer shall disclose to the insured in any promotion or coordination of the service both of the following:

(A) The availability of receiving the service on an in-person basis or via telehealth, if available, from the insured's primary care provider, treating specialist, or from another contracting individual health professional, a contracting clinic, or a contracting health facility consistent with the service and existing timeliness and geographic access standards in Section 10133.5 and regulations promulgated thereunder.

(B) If the insured has coverage for out-of-network benefits, a reminder of the availability of receiving the service either via telehealth or on an in-person basis using the insured's out-of-network benefits, and the cost sharing obligation for out-of-network benefits compared to in-network benefits and balance billing protections for services received from contracted providers.

(2) After being notified pursuant to paragraph (1), the insured chooses to receive the service via telehealth through a third-party corporate telehealth provider.

(3) The insured consents to the service consistent with Section 2290.5 of the Business and Professions Code.

(4) If the insured is currently receiving specialty telehealth services for a mental or behavioral health condition, the insured is given the option of continuing to receive that service with the contracting individual health professional, a contracting clinic, or a contracting health facility.

(b) For purposes of this section, the following definitions shall apply:

(1) “Contracting individual health professional” means a physician and surgeon or other professional who is licensed by the state to deliver or furnish health care services, including mental or behavioral health services, and who is contracted with the insured’s health insurer. A “contracting individual health professional” shall not include a dentist licensed pursuant to the Dental Practice Act (Chapter 4 (commencing with Section 1600) of Division 2 of the Business and Professions Code). Application of this definition is not precluded by a contracting individual health professional’s affiliation with a group.

(2) “Contracting clinic” means a clinic, as defined in Section 1200 of the Health and Safety Code, that is contracted with the insured’s health insurer.

(3) “Contracting health facility” mean a health facility, as defined in Section 1250 of the Health and Safety Code, that is contracted with the insured’s health insurer.

(4) “Third-party corporate telehealth provider” means a corporation directly contracted with a health insurer that provides health care services exclusively through a telehealth technology platform and has no physical location at which a patient can receive services.

(c) If services are provided to an insured through a third-party corporate telehealth provider, a health insurer shall comply with all of the following:

(1) Notify the insured of the insured’s right to access the insured’s medical records pursuant to, and consistent with, Chapter 1 (commencing with Section 123100) of Part 1 of Division 106 of the Health and Safety Code.

(2) Notify the insured that the record of any services provided to the insured through a third-party corporate telehealth provider shall be shared with the insured’s primary care provider, unless the insured objects.

(3) Ensure that the records are entered into a patient record system shared with the insured’s primary care provider or are otherwise provided to the insured’s primary care provider, unless the insured objects, in a manner consistent with state and federal law.

(4) Notify the insured that all services received through the third-party corporate telehealth provider are considered to be in network available at in-network cost-sharing and out-of-pocket costs shall accrue to any applicable deductible or out-of-pocket maximum.

(d) A health insurer shall include in its reports submitted to the department pursuant to Section 10133.5 and regulations adopted pursuant to that section, in a manner specified by the commissioner, all of the following for each product type:

(1) By specialty, the total number of services delivered via telehealth provided by third-party corporate telehealth providers.

(2) The names of each third-party corporate telehealth provider contracted with the insurer and, for each, the number of services provided by specialty.

(3) For each third-party corporate telehealth provider with which it contracts, the percentage of the third-party corporate telehealth provider’s contracted providers available to the insurer’s insured that are also contracting individual health professionals.

(4) For each third-party corporate telehealth provider with which it contracts, the types of telehealth services utilized by insureds, including frequency of use, gender, age, and any other information as determined by the department.

(5) For each enrollee that has accessed services for a third-party corporate telehealth provider, enrollee demographic data, including gender and age, and any other information as determined by the department.

(e) The commissioner shall investigate and take enforcement action, as appropriate, against a health insurer that fails to comply with these requirements and shall periodically evaluate contracts between health insurers and third-party corporate telehealth providers to determine if any audit, evaluation, or enforcement actions should be undertaken by the commissioner.

(f) This section shall not apply when an insured seeks services directly from a third-party corporate telehealth provider.

(Added by Stats. 2021, Ch. 439, Sec. 7. (AB 457) Effective January 1, 2022.)

10123.857. (a) A health insurer that issues, sells, renews, or offers a policy covering dental services, including a specialized health insurance policy covering dental services that offers a service via telehealth to an insured through a third-party corporate telehealth provider shall report to the department, in a manner specified by the department, all of the following for each product type:

(1) The total number of services delivered via telehealth by a third-party corporate telehealth provider.

(2) For each third-party corporate telehealth provider with which it contracts, the percentage of the third-party telehealth provider's contracted providers available to the insurer's insured that are also network providers.

(3) For each third-party corporate telehealth provider with which it contracts, the types of telehealth services utilized by insureds, including information on the gender and age of the insured, and any other information as determined by the department.

(b) A health insurer that issues, sells, renews, or offers a policy covering dental services, including a specialized health care policy covering dental services that offers a service via telehealth to an insured through a third-party corporate telehealth provider, shall disclose to the insured the impact of third-party telehealth visits on the insured's benefit limitations, including frequency limitations and the insured's annual maximum.

(c) Section 10123.856 shall not apply to specialized health insurance policies covering dental services.

(d) For the purposes of this section, "third-party corporate telehealth provider" means a corporation that provides dental services exclusively through a telehealth technology platform and has no physical location at which a patient can receive services, and is directly contracted with a health insurer that issues, sells, renews, or offers a policy, including a specialized health insurance policy, that covers dental services.

(Amended by Stats. 2024, Ch. 444, Sec. 5. (SB 577) Effective January 1, 2025.)

10123.86. (a) Every policy of disability insurance covering hospital, surgical, or medical expenses that is issued, amended, renewed, or delivered on or after January 1, 1999, that provides coverage for surgical procedures known as mastectomies and lymph node dissections, shall do all of the following:

(1) Allow the length of a hospital stay associated with those procedures to be determined by the attending physician and surgeon in consultation with the patient, postsurgery, consistent with sound clinical principles and processes. No disability insurer shall require a treating physician and surgeon to receive prior approval in determining the length of hospital stay following those procedures.

(2) Cover prosthetic devices or reconstructive surgery, including devices or surgery to restore and achieve symmetry for the patient incident to the mastectomy. Coverage for prosthetic devices and reconstructive surgery shall be subject to the deductible and coinsurance conditions applicable to other benefits.

(3) Cover all complications from a mastectomy, including lymphedema.

(b) As used in this section, all of the following definitions apply:

(1) "Coverage for prosthetic devices or reconstructive surgery" means any initial and subsequent reconstructive surgeries or prosthetic devices, and followup care deemed necessary by the attending physician and surgeon.

(2) "Prosthetic devices" means and includes the provision of initial and subsequent prosthetic devices pursuant to an order of the patient's physician and surgeon.

(3) "Mastectomy" means the removal of all or part of the breast for medically necessary reasons, as determined by a licensed physician and surgeon. Partial removal of a breast includes, but is not limited to, lumpectomy, which includes surgical removal of the tumor with clear margins.

(4) "To restore and achieve symmetry" means that, in addition to coverage of prosthetic devices and reconstructive surgery for the diseased breast on which the mastectomy was performed, prosthetic devices and reconstructive surgery for a healthy breast is also covered if, in the opinion of the attending physician and surgeon, this surgery is necessary to achieve normal symmetrical appearance.

(c) No individual, other than a licensed physician and surgeon competent to evaluate the specific clinical issues involved in the care requested, may deny requests for authorization of health care services pursuant to this section.

(d) No insurer shall do any of the following in providing the coverage described in subdivision (a):

(1) Reduce or limit the reimbursement of the attending provider for providing care to an insured in accordance with the coverage requirements.

(2) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an insured in a manner inconsistent with the coverage requirements.

(3) Provide monetary payments or rebates to an insured to encourage acceptance of less than the coverage requirements.

(e) On or after July 1, 1999, every insurer shall include notice of the coverage required by this section in the insurer's evidence of coverage or certificate of insurance.

(f) Nothing in this section shall be construed to limit retrospective utilization review and quality assurance activities by the insurer.

(g) This section shall only apply to health benefit plans, as defined in subdivision (a) of Section 10198.6, except that for accident only, specified disease, or hospital indemnity insurance, coverage for benefits under this section shall apply to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy. Nothing in this section shall be construed as imposing a new benefit mandate on accident only, specified disease, or hospital indemnity insurance.

(Amended by Stats. 2012, Ch. 449, Sec. 5. (SB 255) Effective January 1, 2013.)

10123.864. The provision of medically necessary pasteurized donor human milk obtained from a tissue bank licensed pursuant to Chapter 4.1 (commencing with Section 1635) of Division 2 of the Health and Safety Code is a basic health care service, as described in Sections 10112.27 and 10112.281 and any regulations adopted thereunder.

(Added by Stats. 2024, Ch. 975, Sec. 4. (AB 3059) Effective January 1, 2025.)

10123.865. (a) Commencing no later than July 1, 2012, an individual health insurance policy shall provide coverage for maternity services for all insureds covered under the policy.

(b) For purposes of this section, "maternity services" include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care. This definition of "maternity services" shall remain in effect until the time as federal regulations and guidance issued pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148) define the scope of benefits to be provided under the maternity benefit requirement of that act, after which time the definition of that term under the federal act and associated regulations and guidance shall apply for purposes of this section.

(c) This section shall not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance.

(Amended by Stats. 2018, Ch. 687, Sec. 7. (SB 910) Effective January 1, 2019.)

10123.866. (a) Commencing no later than July 1, 2012, a group health insurance policy shall provide coverage for maternity services for all insureds covered under the policy.

(b) For purposes of this section, "maternity services" include prenatal care, ambulatory care maternity services, involuntary complications of pregnancy, neonatal care, and inpatient hospital maternity care, including labor and delivery and postpartum care. This definition of "maternity services" shall remain in effect until the time as federal regulations and guidance issued pursuant to the federal Patient Protection and Affordable Care Act (Public Law 111-148) define the scope of benefits to be provided under the maternity benefit requirement of that act, after which time the definition of that term under the federal act and associated regulations and guidance shall apply for purposes of this section.

(c) This section shall not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance.

(Amended by Stats. 2018, Ch. 687, Sec. 8. (SB 910) Effective January 1, 2019.)

10123.867. (a) A health insurer shall develop a maternal mental health program designed to promote quality and cost-effective outcomes. The program shall consist of at least one maternal mental health screening to be conducted during pregnancy, at least one additional screening to be conducted during the first six weeks of the postpartum period, and additional postpartum screenings, if determined to be medically necessary and clinically appropriate in the judgment of the treating provider. The program shall be developed consistent with sound clinical principles and processes, and shall include quality measures to encourage screening, diagnosis, treatment, and referral. The program guidelines and criteria shall be provided to relevant medical providers, including all contracting obstetric providers. As part of the maternal mental health program, a health insurer is encouraged to improve screening, treatment, and referral to maternal mental health services, include coverage for doulas, incentivize training opportunities for contracting obstetric providers, and educate insureds about the program.

(b) For the purposes of this section:

(1) “Contracting obstetric provider” means an individual who is certified or licensed pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, or an initiative act referred to in that division, and who is contracted with the insured’s health insurer to provide services under the insured’s health insurance policy.

(2) “Maternal mental health” means a mental health condition that occurs during pregnancy or during the postpartum period and includes, but is not limited to, postpartum depression.

(c) This section does not apply to specialized health insurers, except behavioral health-only insurers that provide coverage for professional mental health services.

(Amended by Stats. 2024, Ch. 815, Sec. 2. (AB 1936) Effective January 1, 2025.)

10123.868. On or before January 1, 2025, a health insurer shall develop a maternal and infant health equity program that addresses racial health disparities in maternal and infant health outcomes through the use of doulas. This may be achieved by integrating the program into existing maternal mental health programs, including those encouraging the coverage of doula care, or by expanding existing doula programs.

(Added by Stats. 2023, Ch. 349, Sec. 3. (AB 904) Effective January 1, 2024.)

10123.869. (a) A contract between a health insurer and a health care provider issued, amended, or renewed on or after January 1, 2025, shall authorize a provider to separately bill for devices, implants, or professional services, or a combination thereof, associated with immediate postpartum contraception if the birth takes place in a general acute care hospital or licensed birth center. The provider contract shall not consider those devices, implants, or services to be part of a payment for a general obstetric procedure.

(b) For purposes of this section, “immediate postpartum contraception” means the postpartum insertion of intrauterine devices or contraceptive implants performed before the insured is discharged from the general acute care hospital or licensed birth center and includes the devices or implants themselves.

(c) This section does not affect an insured’s right to directly access women’s health care services, including contraceptive services, and informed consent.

(Added by Stats. 2024, Ch. 950, Sec. 2. (AB 2129) Effective January 1, 2025.)

10123.87. (a) No individual or group policy of disability insurance that provides coverage for hospital, medical, and surgical benefits that is issued, amended, renewed, or delivered on or after the effective date of the act adding this section, that provides maternity coverage, shall do any of the following:

(1) Restrict benefits for inpatient hospital care to a time period less than 48 hours following a normal vaginal delivery and less than 96 hours following a delivery by caesarean section. However, coverage for inpatient hospital care may be for a time period less than 48 or 96 hours if both of the following conditions are met:

(A) The decision to discharge the mother and newborn before the 48- or 96-hour time period is made by the treating physicians in consultation with the mother.

(B) The policy covers a postdischarge followup visit for the mother and newborn within 48 hours of discharge, when prescribed by the treating physician. The visit shall be provided by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The visit shall include, at a minimum, parent education, assistance and training in breast or bottle feeding, and the performance of any necessary maternal or neonatal physical assessments. The treating physician shall disclose to the mother the availability of a postdischarge visit, including an in-home visit, physician office visit, or a visit to a facility under contract with the insurer. The treating physician, in consultation with the mother, shall determine whether the postdischarge visit shall occur at home, the contracted facility, or the treating physician’s office after assessment of certain factors. These factors shall include, but not be limited to, the transportation needs of the family, and environmental and social risks.

(2) Reduce or limit the reimbursement of the attending provider for providing care to an individual insured in accordance with the coverage requirements.

(3) Provide monetary or other incentives to an attending provider to induce the provider to provide care to an individual insured in a manner inconsistent with the coverage requirements.

(4) Deny a mother or her newborn eligibility, or continued eligibility, to enroll or to renew coverage solely to avoid the coverage requirements.

(5) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum coverage requirements.

(6) Restrict inpatient benefits for the second day of hospital care in a manner that is less than favorable to the mother or her newborn than those provided during the preceding portion of the hospital stay.

(7) Require the treating physician to obtain authorization from the insurer prior to prescribing any services covered by this section.

(b) (1) Every individual or group policy of disability insurance that provides coverage for hospital, medical, and surgical benefits shall include notice of the coverage specified in subdivision (a) in the insurer's evidence of coverage or certificate of insurance for evidences of coverage or certificates of insurance issued on or after January 1, 1998.

(2) Every insurer that issues a policy of disability insurance under paragraph (1) shall provide additional written notice to all females between the ages of 10 and 50 who are covered under those policies of the coverage under subdivision (a) within 60 days of the effective date of this act. The insurer shall provide additional written notice of the coverage specified in subdivision (a) during the course of prenatal care if both of the following conditions are met:

(A) The insurer previously notified policyholders that hospital stays for delivery would be inconsistent with the requirement in subparagraph (A) of paragraph (1) of subdivision (a).

(B) The insurer received notice, whether by receipt of a claim, a request for preauthorization for pregnancy-related services, or other actual notice that the insured is pregnant.

(c) Nothing in this section shall be construed to prohibit an insurer from negotiating the level and type of reimbursement with a provider for care provided in accordance with this section.

(Amended by Stats. 1997, Ch. 798, Sec. 3. Effective October 9, 1997.)

10123.88. (a) Every policy of health insurance covering hospital, medical, or surgical expenses that is issued, amended, renewed, or delivered in this state on or after July 1, 1999, shall cover reconstructive surgery, as defined in subdivision (c), that is necessary to achieve the purposes specified in subparagraph (A) or (B) of paragraph (1) of subdivision (c). Nothing in this section shall be construed to require a policy to provide coverage for cosmetic surgery, as defined in subdivision (d). This section shall only apply to health benefit plans, as defined in subdivision (a) of Section 10198.6, except that for accident only, specified disease, or hospital indemnity insurance, coverage for benefits under this section shall apply to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy. Nothing in this section shall be construed as imposing a new benefit mandate on accident only, specified disease, or hospital indemnity insurance.

(b) No individual, other than a licensed physician competent to evaluate the specific clinical issues involved in the care requested, may deny initial requests for authorization of coverage for treatment pursuant to this section. For a treatment authorization request submitted by a podiatrist or an oral and maxillofacial surgeon, the request may be reviewed by a similarly licensed individual, competent to evaluate the specific clinical issues involved in the care requested.

(c) (1) "Reconstructive surgery" means surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease to do either of the following:

(A) To improve function.

(B) To create a normal appearance, to the extent possible.

(2) As of July 1, 2010, "reconstructive surgery" shall include medically necessary dental or orthodontic services that are an integral part of reconstructive surgery, as defined in paragraph (1), for cleft palate procedures.

(3) For purposes of this section, "cleft palate" means a condition that may include cleft palate, cleft lip, or other craniofacial anomalies associated with cleft palate.

(d) Nothing in this section shall be construed to require an insurer to provide coverage for cosmetic surgery. "Cosmetic surgery" means surgery that is performed to alter or reshape normal structures of the body in order to improve the patient's appearance.

(e) In interpreting the definition of reconstructive surgery, an insurer may utilize prior authorization and utilization review that may include, but need not be limited to, any of the following:

(1) Denial of the proposed surgery if there is another more appropriate surgical procedure that will be approved for the enrollee.

(2) Denial of the proposed surgery or surgeries if the procedure or procedures, in accordance with the standard of care as practiced by physicians specializing in reconstructive surgery, offer only a minimal improvement in the appearance of the enrollee.

(3) Denial of payment for procedures performed without prior authorization.

(Amended by Stats. 2009, Ch. 604, Sec. 2. (SB 630) Effective January 1, 2010.)

10123.89. (a) On and after July 1, 2000, every policy of disability insurance issued, amended, delivered, or renewed in this state that provides coverage for hospital, medical, or surgical expenses shall provide coverage for the testing and treatment of phenylketonuria (PKU) under the terms and conditions of the policy.

(b) Coverage for treatment of phenylketonuria (PKU) shall include those formulas and special food products that are part of a diet prescribed by a licensed physician and managed by a health care professional in consultation with a physician who specializes in the treatment of metabolic disease and who participates in or is authorized by the insurer, provided that the diet is deemed medically necessary to avert the development of serious physical or mental disabilities or to promote normal development or function as a consequence of phenylketonuria (PKU).

(c) Coverage pursuant to this section is not required except to the extent that the cost of necessary formulas and special food products exceeds the cost of a normal diet.

(d) For purposes of this section, the following definitions shall apply:

(1) “Formula” means an enteral product or enteral products for use at home that are prescribed by a physician or nurse practitioner, or ordered by a registered dietician upon referral by a health care provider authorized to prescribe dietary treatments, as medically necessary for the treatment of phenylketonuria (PKU).

(2) “Special food product” means a food product that is both of the following:

(A) Prescribed by a physician or nurse practitioner for the treatment of phenylketonuria (PKU) and is consistent with the recommendations and best practices of qualified health professionals with expertise germane to, and experience in the treatment and care of, phenylketonuria (PKU). It does not include a food that is naturally low in protein, but may include a food product that is specially formulated to have less than one gram of protein per serving.

(B) Used in place of normal food products, such as grocery store foods, used by the general population.

(e) This section shall not apply to vision-only, dental-only, accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, or disability income insurance, except that for accident only, specified disease, or hospital indemnity coverage, coverage for benefits under this section shall apply to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy or contract. Nothing in this section shall be construed as imposing a new benefit mandate on accident only, specified disease, or hospital indemnity insurance.

(Added by Stats. 1999, Ch. 541, Sec. 2. Effective January 1, 2000.)

10123.9. On and after January 1, 1980, every group policy of disability insurance which covers hospital, medical, or surgical expenses on a group basis, and which offers maternity coverage in such groups, shall also offer coverage for prenatal diagnosis of genetic disorders of the fetus by means of diagnostic procedures in cases of high-risk pregnancy. Such coverage shall be offered under such terms and conditions as may be agreed upon between the insurer and the group policyholder. Every group policy of disability insurance shall communicate the availability of such coverage to all group policyholders and to all groups with whom they are negotiating.

(Added by Stats. 1979, Ch. 629.)

10123.91. (a) On or after January 1, 2009, every insurer that issues, amends, or renews an individual or group policy of health insurance that covers hospital, medical, or surgical expenses shall provide coverage for human immunodeficiency virus (HIV) testing, regardless of whether the testing is related to a primary diagnosis.

(b) It shall remain within the sole discretion of the health insurer as to the provider of the testing with which it chooses to contract. Reimbursement shall be provided according to the respective principles and policies of the health insurer.

(Added by Stats. 2008, Ch. 631, Sec. 2. Effective January 1, 2009.)

10123.10. (a) Every disability insurer transacting business in this state shall, on or after January 1, 1979, make available and offer to include in every group disability policy providing hospital, medical or surgical expense benefits payable on an expense incurred basis, to be delivered or issued for delivery in this state, benefits for home health care as set forth in this section provided by a licensed home health agency subject to the right of the group policyholder to reject the benefits or to select any alternative level of benefits as may be offered by the insurer.

In rural areas where there are no licensed health agencies or in which the supply of home health agency services does not meet the needs of the community, the services of visiting nurses, if available, may be substituted for the services of the home health agency, subject to the terms and conditions set forth in subdivision (c).

(b) Every self-insured employee welfare benefit plan containing hospital, medical, or surgical expense benefits or service benefits delivered on or after January 1, 1979, shall make available and offer to include benefits for home health care as set forth in this section provided by a licensed home health agency subject to the right of the employer or the employee organization to reject the benefits or accept any alternative level of benefits as may be offered by the self-insured welfare benefit plan.

In rural areas where there are no licensed health agencies or in which the supply of home health agency services does not meet the needs of the community, the services of visiting nurses, if available, may be substituted for the services of the home health agency, subject to the terms and conditions set forth in subdivision (c).

(c) As used in this section:

(1) “Home health care” means the continued care and treatment of an insured person who is under the direct care and supervision of a physician but only if (i) continued hospitalization would have been required if home health care were not provided, (ii) the home health treatment plan is established and approved by a physician within 14 days after an inpatient hospital confinement has ended and such treatment plan is for the same or related condition for which the insured person was hospitalized, and (iii) home health care commences within 14 days after the hospital confinement has ended. “Home health services” consist of, but shall not be limited to, the following: (i) part-time or intermittent skilled nursing services provided by a registered nurse or licensed vocational nurse; (ii) part-time or intermitent home health aide services which provide supportive services in the home under the supervision of a registered nurse or a physical, speech or occupational therapist; (iii) physical, occupational or speech therapy; and (iv) medical supplies, drugs and medicines prescribed by a physician and related pharmaceutical services, and laboratory services to the extent such charges or costs would have been covered under the policy if the insured person had remained in the hospital.

(2) “Home health agency” means a public or private agency or organization licensed by the State Department of Health Services in accordance with the provisions of Chapter 8 (commencing with Section 1725) of Division 2 of the Health and Safety Code.

(d) The policy may contain a limitation on the number of home health visits for which benefits are payable, but the number of such visits shall not be less than 100 in any calendar year or in any continuous 12-month period for each person covered under the policy. Except for a home health aide, each visit by a representative of a home health agency shall be considered as one home health visit. A visit of four hours or less by a home health aide shall be considered as one home health visit.

(e) Home health care benefits may be subject to an annual deductible of not more than fifty dollars ($50) for each person covered under a policy, and may be subject to a coinsurance provision which provides coverage of not less than 80 percent of the reasonable charges for such services.

(f) Nothing in this section shall preclude an insurer or plan offering other health care benefits provided in the home.

(Added by Stats. 1978, Ch. 1130.)

10123.11. (a) No insurer shall deny a claim under a group disability policy for hospital, medical, surgical, dental, or optometric services for the sole reason that the individual served was confined in a city or county jail as a prisoner, or was a juvenile detained in any facility if such individual is otherwise entitled to benefits under such group disability policy and incurs expense for the services so provided during confinement. This provision shall apply to any group disability policy entered into or renewed on or after July 1, 1980, whether or not such policy contains any provision terminating benefits under such policy upon an individual’s confinement in a city or county jail or juvenile detention facility.

(b) No self-insured employee welfare benefit plan shall deny a claim under a plan for hospital, medical, surgical, dental, or optometric services for the reason that the individual served was confined in a city or county jail as a prisoner, or was a juvenile detained in any facility, if such individual is otherwise entitled to benefits under such plan and incurs expense for the services so provided during confinement. This provision shall apply to any self-insured employee welfare benefit plan entered into or renewed on or after July 1, 1980, whether or not such plan contains any provision terminating benefits under such plan upon an individual’s confinement in a city or county jail or juvenile detention facility.

(Added by Stats. 1980, Ch. 90, Sec. 2. Effective May 9, 1980.)

10123.12. Every health insurer, including those insurers that contract for alternative rates of payment pursuant to Section 10133, and every self-insured employee welfare benefit plan that will affect the choice of physician, hospital, or other health care providers shall include within its disclosure form and within its evidence or certificate of coverage a statement clearly describing how participation in the policy or plan may affect the choice of physician, hospital, or other health care providers, and describing the nature and extent of the financial liability that is, or that may be, incurred by the insured, enrollee, or covered dependents if care is furnished by a provider that does not have a contract with the insurer or plan to provide service at alternative rates of payment pursuant to Section 10133. The form shall clearly inform prospective insureds or plan enrollees that participation in the policy or plan will affect the person’s choice in this regard by placing the following statement in a conspicuous place on all material required to be given to prospective insureds or plan enrollees including promotional and descriptive material, disclosure forms, and certificates and evidences of coverage:

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED

It is not the intent of this section to require that the names of individual health care providers be enumerated to prospective insureds or enrollees.

If a health insurer providing coverage for hospital, medical, or surgical expenses provides a list of facilities to patients or contracting providers, the insurer shall include within the provider listing a notification that insureds or enrollees may contact the insurer in order to obtain a list of the facilities with which the health insurer is contracting for subacute care and/or transitional inpatient care.

(Amended by Stats. 2005, Ch. 441, Sec. 3. Effective January 1, 2006.)

10123.13. (a) Every insurer issuing group or individual policies of health insurance that cover hospital, medical, or surgical expenses, including those telehealth services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse claims or any portion of any claim, whether in state or out of state, for those expenses as soon as practical, but no later than 30 working days after receipt of the claim by the insurer unless the claim or portion thereof is contested by the insurer, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 working days after receipt of the claim by the insurer. The notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting or denying the claim. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason for contesting or denying the claim. The insurer shall provide a copy of the notice to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice shall advise the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that the insurer contested or denied, and the notice shall include the address, internet website address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. The notice to the insured may also be included on the explanation of benefits.

(b) If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 30 working days after receipt, interest shall accrue and shall be payable at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period.

(c) For purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant. If an insurer has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim determined to be payable within 30 working days of receipt of that information, interest shall accrue and be payable at a rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period.

(d) The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

(e) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.

(Amended by Stats. 2024, Ch. 763, Sec. 6. (AB 3275) Effective January 1, 2025. Repealed as of January 1, 2026, by its own provisions. See later operative version added by Sec. 7 of Stats. 2024, Ch. 763.)

10123.13. (a) Every insurer issuing group or individual policies of health insurance that cover hospital, medical, or surgical expenses, including those telehealth services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse a complete claim or portion thereof, whether in state or out of state, for those expenses as soon as practicable, but no later than 30 calendar days after receipt of the claim by the insurer, in which case the claimant shall be notified, in writing, that the claim is contested or denied, within 30 calendar days after receipt of the claim by the insurer. The notice that a claim is being contested or denied shall identify the portion of the claim that is contested or denied and the specific reasons including for each reason the factual and legal basis known at that time by the insurer for contesting or denying the claim. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or the legal basis for its reason for contesting or denying the claim. The insurer shall provide a copy of the notice to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice shall advise the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that the insurer contested or denied, and the notice shall include the address, internet website address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain

a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. The notice to the insured may also be included on the explanation of benefits.

(b) If an uncontested claim is not reimbursed by delivery to the claimant's address of record within 30 calendar days after receipt, interest shall accrue at the rate of 15 percent per annum beginning with the first calendar day after the 30-calendar-day period. An insurer shall automatically include in its payment of the claim all interest that has accrued pursuant to this section without requiring the claimant to submit a request for the interest amount. An insurer failing to comply with this requirement shall pay the claimant a fee of the greater an additional of fifteen dollars ($15) or 10 percent of the accrued interest.

(c) (1) For purposes of this section, a claim, or portion thereof, is reasonably contested when the insurer has not received a completed claim and all information necessary to determine payer liability for the claim, or has not been granted reasonable access to information concerning provider services. Information necessary to determine liability for the claims includes, but is not limited to, reports of investigations concerning fraud and misrepresentation, and necessary consents, releases, and assignments, a claim on appeal, or other information necessary for the insurer to determine the medical necessity for the health care services provided to the claimant. An insurer may not contest a complete claim that is consistent with an approved prior authorization request if the prior authorization approval has been provided in the appropriate field on the claim.

(2) If an insurer has received all of the information necessary to determine payer liability for a contested claim and has not reimbursed a claim determined to be payable within 30 calendar days of receipt of that information, interest shall accrue and be payable at a rate of 15 percent per annum beginning with the first calendar day after the 30-calendar-day period.

(d) The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

(e) (1) The department may issue guidance and regulations relating to this section. The guidance and regulations shall not be subject to the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until December 31, 2027.

(2) After January 1, 2028, the department may issue regulations relating to this section subject to the rulemaking provisions of the Administrative Procedure Act ((Chapter 3.5 commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until December 31, 2030.

(f) This section shall become operative on January 1, 2026.

(Repealed (in Sec. 6) and added by Stats. 2024, Ch. 763, Sec. 7. (AB 3275) Effective January 1, 2025. Operative January 1, 2026, by its own provisions.)

10123.131. (a) An insurer shall pay a provider for duplicating all information it requests in connection with a contested claim, and for patient records, as follows:

(1) Except as provided in paragraph (2), the insurer shall pay the provider for copying twenty-five cents ($0.25) per page, or fifty cents ($0.50) per page for records that are copied from microfilm.

(2) The insurer shall pay the provider all reasonable costs, not exceeding actual costs, incurred by the provider in providing the insurer copies of X-rays, or tracings derived from electrocardiography, electroencephalography, or electromyography.

(b) No insurer subject to this section shall request information that is not reasonably necessary to determine liability for payment of a claim.

(c) The obligation of the insurer to comply with this section shall not be deemed to be waived when the insurer requires its contracting entities to pay claims for covered services.

(d) This section shall not apply to contractual arrangements between an insurer and its agent, an insurer and a provider, or a provider and its agent for the costs associated with the provision of duplication services.

(Added by Stats. 2000, Ch. 844, Sec. 2. Effective January 1, 2001.)

10123.132. (a) Every disability insurer that covers hospital, medical, or surgical expenses and that reviews and approves the medical necessity or appropriateness of requests by providers prior to, or concurrently with, the provision of health care services to insureds, shall prominently indicate on each insured's identification card whether a separate telephone number must be called to verify eligibility for benefits and coverage.

(b) A written notice shall accompany the initial mailing of the insured's identification card modified pursuant to subdivision (a). The notice shall indicate that the insured's identification card includes a telephone number that may be used to verify eligibility for benefits and coverage. The notice shall also inform the insured that review and approval of a health care service based on medical necessity or appropriateness does not constitute eligibility for benefits and coverage pursuant to the policy or contract.

(Added by renumbering Section 10123.135 (as added by Stats. 1999, Ch. 88) by Stats. 2000, Ch. 241, Sec. 2. Effective January 1, 2001.)

10123.135. (a) Every disability insurer, or an entity with which it contracts for services that include utilization review or utilization management functions, that covers hospital, medical, or surgical expenses and that prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, or that delegates these functions to medical groups or independent practice associations or to other contracting providers, shall comply with this section.

(b) A disability insurer that is subject to this section, or any entity with which an insurer contracts for services that include utilization review or utilization management functions, shall have written policies and procedures establishing the process by which the insurer prospectively, retrospectively, or concurrently reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers of health care services for insureds. These policies and procedures shall ensure that decisions based on the medical necessity of proposed health care services are consistent with criteria or guidelines that are supported by clinical principles and processes. These criteria and guidelines shall be developed pursuant to subdivision (f). These policies and procedures, and a description of the process by which an insurer, or an entity with which an insurer contracts for services that include utilization review or utilization management functions, reviews and approves, modifies, delays, or denies requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, shall be filed with the commissioner, and shall be disclosed by the insurer to insureds and providers upon request, and by the insurer to the public upon request.

(c) If the number of insureds covered under health benefit plans in this state that are issued by an insurer subject to this section constitute at least 50 percent of the number of insureds covered under health benefit plans issued nationwide by that insurer, the insurer shall employ or designate a medical director who holds an unrestricted license to practice medicine in this state issued pursuant to Section 2050 of the Business and Professions Code or the Osteopathic Initiative Act, or the insurer may employ a clinical director licensed in California whose scope of practice under California law includes the right to independently perform all those services covered by the insurer. The medical director or clinical director shall ensure that the process by which the insurer reviews and approves, modifies, delays, or denies, based in whole or in part on medical necessity, requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, complies with the requirements of this section. Nothing in this subdivision shall be construed as restricting the existing authority of the Medical Board of California.

(d) If an insurer subject to this section, or individuals under contract to the insurer to review requests by providers, approve the provider's request pursuant to subdivision (b), the decision shall be communicated to the provider pursuant to subdivision (h).

(e) An individual, other than a licensed physician or a licensed health care professional who is competent to evaluate the specific clinical issues involved in the health care services requested by the provider, may not deny or modify requests for authorization of health care services for an insured for reasons of medical necessity. The decision of the physician or other health care provider shall be communicated to the provider and the insured pursuant to subdivision (h).

(f) (1) An insurer shall disclose, or provide for the disclosure, to the commissioner and to network providers, the process the insurer, its contracting provider groups, or any entity with which it contracts for services that include utilization review or utilization management functions, uses to authorize, delay, modify, or deny health care services under the benefits provided by the insurance contract, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. An insurer shall also disclose those processes to policyholders or persons designated by a policyholder, or to any other person or organization, upon request.

(2) The criteria or guidelines used by an insurer, or an entity with which an insurer contracts for utilization review or utilization management functions, to determine whether to authorize, modify, delay, or deny health care services, shall comply with all of the following:

(A) Be developed with involvement from actively practicing health care providers.

(B) Be consistent with sound clinical principles and processes.

(C) Be evaluated, and updated if necessary, at least annually.

(D) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the policyholder in that specified case.

(E) Be available to the public upon request. An insurer shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. An insurer may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph that are limited to copying and postage costs. The insurer may also make the criteria or guidelines available through electronic communication means.

(3) The disclosure required by subparagraph (E) of paragraph (2) shall be accompanied by the following notice: “The materials provided to you are guidelines used by this insurer to authorize, modify, or deny health care benefits for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your insurance contract.”

(g) If an insurer subject to this section requests medical information from providers in order to determine whether to approve, modify, or deny requests for authorization, the insurer shall request only the information reasonably necessary to make the determination.

(h) In determining whether to approve, modify, or deny requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds, based in whole or in part on medical necessity, every insurer subject to this section shall meet the following requirements:

(1) Decisions to approve, modify, or deny, based on medical necessity, requests by providers prior to, or concurrent with, the provision of health care services to insureds that do not meet the requirements for the time period for review required by paragraph (2), shall be made in a timely fashion appropriate for the nature of the insured’s condition, not to exceed five business days from the insurer’s receipt of the information reasonably necessary and requested by the insurer to make the determination. In cases where the review is retrospective, the decision shall be communicated to the individual who received services, or to the individual’s designee, within 30 days of the receipt of information that is reasonably necessary to make this determination, and shall be communicated to the provider in a manner that is consistent with current law. For purposes of this section, retrospective reviews shall be for care rendered on or after January 1, 2000.

(2) When the insured’s condition is such that the insured faces an imminent and serious threat to the insured’s health, including, but not limited to, the potential loss of life, limb, or other major bodily function, or the normal timeframe for the decisionmaking process, as described in paragraph (1), would be detrimental to the insured’s life or health or could jeopardize the insured’s ability to regain maximum function, decisions to approve, modify, or deny requests by providers prior to, or concurrent with, the provision of health care services to insureds shall be made in a timely fashion, appropriate for the nature of the insured’s condition, but not to exceed 72 hours or, if shorter, the period of time required under Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder, after the insurer’s receipt of the information reasonably necessary and requested by the insurer to make the determination.

(3) Decisions to approve, modify, or deny requests by providers for authorization prior to, or concurrent with, the provision of health care services to insureds shall be communicated to the requesting provider within 24 hours of the decision. Except for concurrent review decisions pertaining to care that is underway, which shall be communicated to the insured’s treating provider within 24 hours, decisions resulting in denial, delay, or modification of all or part of the requested health care service shall be communicated to the insured in writing within two business days of the decision. In the case of concurrent review, care shall not be discontinued until the insured’s treating provider has been notified of the insurer’s decision and a care plan has been agreed upon by the treating provider that is appropriate for the medical needs of that patient.

(4) Communications regarding decisions to approve requests by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds shall specify the specific health care service approved. Responses regarding decisions to deny, delay, or modify health care services requested by providers prior to, retrospectively, or concurrent with the provision of health care services to insureds shall be communicated to insureds in writing, and to providers initially by telephone or facsimile, except with regard to decisions rendered retrospectively, and then in writing, and shall include a clear and concise explanation of the reasons for the insurer’s decision, a description of the criteria or guidelines used, and the clinical reasons for the decisions regarding medical necessity. Any written communication to a physician or other health care provider of a denial, delay, or modification or a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification. Responses shall also include information as to how the provider or the insured may file an appeal with the insurer or seek department review under the unfair practices provisions of Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1 and the regulations adopted thereunder.

(5) If the insurer cannot make a decision to approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2) because the insurer is not in receipt of all of the information reasonably necessary and requested, or because the insurer requires consultation by an expert reviewer, or because the insurer has asked that an additional examination or test be performed upon the insured, provided that the examination or test is reasonable and consistent with good medical practice, the insurer shall, immediately upon the expiration of the timeframe specified in paragraph (1) or (2), or as soon as the insurer becomes aware that it will not meet the timeframe, whichever occurs first, notify the provider and the insured, in writing, that the insurer cannot make a decision to approve, modify, or deny the request for authorization within the required timeframe, and specify the information requested but not received, or the expert reviewer to be consulted, or the additional examinations or tests required. The insurer shall also notify the provider and enrollee of the anticipated date on which a decision may be rendered.

Upon receipt of all information reasonably necessary and requested by the insurer, the insurer shall approve, modify, or deny the request for authorization within the timeframes specified in paragraph (1) or (2), whichever applies.

(6) If the commissioner determines that an insurer has failed to meet any of the timeframes in this section, or has failed to meet any other requirement of this section, the commissioner may assess, by order, administrative penalties for each failure. A proceeding for the issuance of an order assessing administrative penalties shall be subject to appropriate notice to, and an opportunity for a hearing with regard to, the person affected. The administrative penalties shall not be deemed an exclusive remedy for the commissioner. These penalties shall be paid to the Insurance Fund.

(i) Every insurer subject to this section shall maintain telephone access for providers to request authorization for health care services.

(j) (1) A disability insurer, including a specialized health insurer that uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, or that contracts with or otherwise works through an entity that uses an artificial intelligence, algorithm, or other software tool for the purpose of utilization review or utilization management functions, based in whole or in part on medical necessity, shall comply with this section and shall ensure all of the following:

(A) The artificial intelligence, algorithm, or other software tool bases its determination on the following information, as applicable:

(i) An insured's medical or other clinical history.

(ii) Individual clinical circumstances as presented by the requesting provider.

(iii) Other relevant clinical information contained in the insured's medical or other clinical record.

(B) The artificial intelligence, algorithm, or other software tool does not base its determination solely on a group dataset.

(C) The artificial intelligence, algorithm, or other software tool's criteria and guidelines complies with this chapter and applicable state and federal law.

(D) The artificial intelligence, algorithm, or other software tool does not supplant health care provider decisionmaking.

(E) The use of the artificial intelligence, algorithm, or other software tool does not discriminate, directly or indirectly, against insureds in violation of state or federal law.

(F) The artificial intelligence, algorithm, or other software tool is fairly and equitably applied, including in accordance with any applicable regulations and guidance issued by the federal Department of Health and Human Services.

(G) The artificial intelligence, algorithm, or other software tool is open to inspection for audit or compliance reviews by the department pursuant to applicable state and federal law.

(H) Disclosures pertaining to the use and oversight of the artificial intelligence, algorithm, or other software tool are contained in the written policies and procedures, as required by subdivision (b).

(I) The artificial intelligence, algorithm, or other software tool's performance, use, and outcomes are periodically reviewed and revised to maximize accuracy and reliability.

(J) Patient data is not used beyond its intended and stated purpose, consistent with the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code) and the federal Health Insurance Portability and Accountability Act of 1996 (Public Law 104-191), as applicable.

(K) The artificial intelligence, algorithm, or other software tool does not directly or indirectly cause harm to the insured.

(2) Notwithstanding paragraph (1), the artificial intelligence, algorithm, or other software tool shall not deny, delay, or modify health care services based, in whole or in part, on medical necessity. A determination of medical necessity shall be made only by a licensed physician or licensed health care professional competent to evaluate the specific clinical issues involved in the health care services requested by the provider, as provided in subdivision (e), by reviewing and considering the requesting provider's recommendation, the insured's medical or other clinical history, as applicable, and individual clinical circumstances.

(3) For purposes of this subdivision, "artificial intelligence" means an engineered or machine-based system that varies in its level of autonomy and that can, for explicit or implicit objectives, infer from the input it receives how to generate outputs that can influence physical or virtual environments.

(4) This subdivision shall apply to utilization review or utilization management functions that prospectively, retrospectively, or concurrently review requests for covered health care services.

(5) A disability insurer subject to this subdivision shall comply with applicable federal rules and guidance issued by the federal Department of Health and Human Services regarding the use of artificial intelligence, algorithm, or other software tools. The department may issue guidance to implement this paragraph within one year of the adoption of federal rules or the issuance of guidance by the federal Department of Health and Human Services regarding the use of artificial intelligence, algorithm, or other software tools. Such guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code).

(6) For purposes of implementing this subdivision, the department may enter into exclusive or nonexclusive contracts, or amend existing contracts, on a bid or negotiated basis. Contracts entered into or amended pursuant to this subdivision shall be exempt from Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, Section 19130 of the Government Code, and Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(k) Nothing in this section shall cause a disability insurer to be defined as a health care provider for purposes of any provision of law, including, but not limited to, Section 6146 of the Business and Professions Code, Sections 3333.1 and 3333.2 of the Civil Code, and Sections 340.5, 364, 425.13, 667.7, and 1295 of the Code of Civil Procedure.

(Amended by Stats. 2024, Ch. 879, Sec. 2. (SB 1120) Effective January 1, 2025.)

10123.137. (a) Each contract between a health insurer and a provider shall contain provisions requiring a fast, fair, and cost-effective dispute resolution mechanism under which providers may submit disputes to the insurer, and requiring the insurer to inform its providers, upon contracting with the insurer, or upon change to these provisions, of the procedures for processing and resolving disputes, including the location and telephone number where information regarding disputes may be submitted.

(b) An insurer shall also ensure that a dispute resolution mechanism is accessible to noncontracting providers for the purpose of resolving billing and claims disputes.

(c) Disputes are to be submitted to the insurer in writing and shall include provider name, provider tax identification number, patient name, insurer's identification information, dates of service, description of dispute, and, if applicable, billed and paid amounts. The insurer shall resolve each provider dispute consistent with applicable law and issue a written determination within 45 working days after the date of receipt of the provider dispute.

(d) On and after July 1, 2007, an insurer shall annually submit a report to the department regarding its dispute resolution mechanism. The report shall be public information and include, at a minimum, information on the number of providers that utilized the dispute resolution mechanism and a summary of the disposition of those disputes. To the extent the commissioner requires detailed information disclosing emerging or established patterns of provider disputes or corrective action by the insurer, the commissioner may maintain the confidentiality of any information found to be proprietary, upon written request of the insurer. In no event shall the commissioner find the required minimum information described in this subdivision to be proprietary.

(e) If an insurer has an affiliated or subsidiary company that is licensed as a health care service plan under Chapter 2.2 (commencing with Section 1340) of Division 2 of the Health and Safety Code, the insurer may use the same procedures relating to the provider dispute resolution process established by the affiliated or subsidiary entity pursuant to subdivision (h) of Section 1367 of the Health and Safety Code.

(Added by Stats. 2005, Ch. 723, Sec. 4. Effective January 1, 2006.)

10123.14. On and after January 1, 1990, every self-insured employee welfare benefit plan containing hospital, medical, or surgical expense benefits or service benefits may provide coverage for the treatment of alcoholism, chemical dependency, or nicotine use under such terms and conditions as may be agreed upon between the self-insured welfare benefit plan and the member, where the treatment may take place in facilities licensed to provide alcoholism or chemical dependency services under Chapter 2 (commencing with Section 1250) of Division 2 of the Health and Safety Code.

Treatment for nicotine use may be subject to separate deductibles, copayments, and overall cost limitations as determined by the plan.

(Added by Stats. 1989, Ch. 688, Sec. 3.)

10123.141. (a) Every policy of expense incurred hospital, medical, or surgical insurance issued, amended, or renewed on or after January 1, 1991, on a group basis, except for policies that only provide coverage for specified diseases or other limited benefit coverage, shall offer coverage as an option for special footwear needed by persons who suffer from foot disfigurement under the terms and conditions agreed upon between the group contract holder and the insurer.

(b) As used in this section, foot disfigurement shall include, but not be limited to, disfigurement from cerebral palsy, arthritis, polio, spina bifida, and diabetes, and foot disfigurement caused by accident or developmental disability.

(Amended by Stats. 2006, Ch. 538, Sec. 463. Effective January 1, 2007.)

10123.145. (a) (1) Whenever an insurer issuing group or individual policies of disability insurance which covers hospital, medical, or surgical expenses determines that in reimbursing a claim for provider services an institutional or professional provider has been overpaid, and then notifies the provider in writing through a separate notice identifying the overpayment and the amount of the overpayment, the provider shall reimburse the insurer within 30 working days of receipt by the provider of the notice of overpayment unless the overpayment or portion thereof is contested by the provider in which case the insurer shall be notified, in writing, within 30 working days. The notice that an overpayment is being contested shall identify the portion of the overpayment that is contested and the specific reasons for contesting the overpayment.

(2) If the provider does not make reimbursement for an uncontested overpayment within 30 working days after receipt, interest shall accrue at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period.

(3) A prorated cost-sharing payment, or any portion thereof, made to a pharmacist for the dispensing of a partial fill pursuant to Section 4052.10 of the Business and Professions Code shall not be considered to be an overpayment pursuant to this section.

(b) (1) This subdivision shall only apply to a health insurance policy covering dental services or a specialized health insurance policy covering dental services.

(2) The insurer's notice of overpayment shall inform the provider how to access the insurer's dispute resolution mechanism offered pursuant to subdivision (a) of Section 10123.137. The notice shall include the name and address to which the dispute should be submitted and a statement that Section 10123.145 of the Insurance Code requires a provider to reimburse the insurer for an overpayment within 30 working days of receipt by the provider of the notice of overpayment unless the provider contests the overpayment within 30 working days. The notice shall also include information clearly identifying the claim, the name of the patient, the date of service, and a clear explanation of the basis upon which the insurer believes the amount paid on the claim was in excess of the amount due, including interest and penalties on the claim. The notice shall also include a statement that if the provider does not make reimbursement of an uncontested overpayment within 30 working days after receipt of the notice, interest shall accrue at a rate of 10 percent per annum.

(Amended by Stats. 2017, Ch. 615, Sec. 5. (AB 1048) Effective January 1, 2018.)

10123.147. (a) Every insurer issuing group or individual policies of health insurance that cover hospital, medical, or surgical expenses, including those telehealth services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse each complete claim, or portion thereof, whether in state or out of state, as soon as practical, but no later than 30 working days after receipt of the complete claim by the insurer. However, an insurer may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 working days after receipt of the complete claim by the insurer. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by revenue code, and the specific reasons for the denial, including the factual and legal basis known at that time by the insurer for each reason. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or legal basis for its reason to deny the claim. The insurer shall provide a copy of the notice required by this subdivision to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice required by this subdivision shall include a statement advising the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that was contested or denied by the insurer and the address, internet website address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. An insurer may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the insurer pays those charges specified in subdivision (b).

(b) If a complete claim, or portion thereof, that is neither contested nor denied, is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt, the insurer shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period. An insurer shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(c) For the purposes of this section, a claim, or portion thereof, is reasonably contested if the insurer has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department

report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. However, if the insurer requests a copy of the emergency department report within the 30 working days after receipt of the electronic claim from the institutional provider, the insurer may also request additional reasonable relevant information within 30 working days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 working days of receipt of the claim. The provider shall provide the insurer reasonable relevant information within 15 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the insurer requires further information, the insurer shall have an additional 15 working days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. An insurer shall specify, in a written notice to the provider within 30 working days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the insurer has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the insurer shall have 30 working days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the 30 working days after receipt of the additional information, the insurer shall pay the greater of fifteen dollars ($15) per year or interest at the rate of 10 percent per annum beginning with the first calendar day after the 30-working-day period. An insurer shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor.

(f) An insurer shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the insurer's actions to resolve the claim, to the provider that submitted the claim.

(g) An insurer shall not request or require that a provider waive its rights pursuant to this section.

(h) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 of the Health and Safety Code in the United States on or after September 1, 1999.

(i) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 10123.13.

(j) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

(k) This section shall remain in effect only until January 1, 2026, and as of that date is repealed.

(Amended by Stats. 2024, Ch. 763, Sec. 8. (AB 3275) Effective January 1, 2025. Repealed as of January 1, 2026, by its own provisions. See later operative version added by Sec. 9 of Stats. 2024, Ch. 763.)

10123.147. (a) Every insurer issuing group or individual policies of health insurance that cover hospital, medical, or surgical expenses, including those telehealth services covered by the insurer as defined in subdivision (a) of Section 2290.5 of the Business and Professions Code, shall reimburse a complete claim or portion thereof, whether in state or out of state, as soon as practicable, but no later than 30 calendar days after receipt of the complete claim by the insurer. However, an insurer may contest or deny a claim, or portion thereof, by notifying the claimant, in writing, that the claim is contested or denied, within 30 calendar days after receipt of the claim by the insurer. The notice that a claim, or portion thereof, is contested shall identify the portion of the claim that is contested, by procedure or revenue code, and the specific information needed from the provider to reconsider the claim. The notice that a claim, or portion thereof, is denied shall identify the portion of the claim that is denied, by procedure or revenue code, and the specific reasons for the denial, including the factual and legal basis known at that time by the insurer for each reason. If the reason is based solely on facts or solely on law, the insurer is required to provide only the factual or legal basis for its reason to deny the claim. The insurer shall provide a copy of the notice required by this subdivision to each insured who received services pursuant to the claim that was contested or denied and to the insured's health care provider that provided the services at issue. The notice required by this subdivision shall include a statement advising the provider who submitted the claim on behalf of the insured or pursuant to a contract for alternative rates of payment and the insured that either may seek review by the department of a claim that was contested or denied by the insurer and the address, internet website address, and telephone number of the unit within the department that performs this review function. The notice to the provider may be included on either the explanation of benefits or remittance advice and shall also contain a statement advising the provider of its right to enter into the dispute resolution process described in Section 10123.137. An insurer may delay payment of an uncontested portion of a complete claim for reconsideration of a contested portion of that claim so long as the insurer pays those charges specified in subdivision (b).

(b) If a complete claim or portion thereof that is neither contested nor denied is not reimbursed by delivery to the claimant's address of record within the 30 calendar days after receipt, the insurer shall pay the greater of fifteen dollars ($15) per year or a rate of 15 percent per annum beginning with the first calendar day after the 30-calendar-day period. An insurer shall automatically include the fifteen dollars ($15) per year or interest due in the payment made to the claimant, without requiring a request therefor. An insurer failing to comply with this requirement shall pay the claimant the greater of an additional fifteen dollars ($15) or a fee of 10 percent of the accrued interest.

(c) For the purposes of this section, a claim or portion thereof, is reasonably contested if the insurer has not received the completed claim. A paper claim from an institutional provider shall be deemed complete upon submission of a legible emergency department report and a completed UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 calendar days of receipt of the claim. An electronic claim from an institutional provider shall be deemed complete upon submission of an electronic equivalent to the UB 92 or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 calendar days of receipt of the claim. However, if the insurer requests a copy of the emergency department report within the 30 calendar days after receipt of the electronic claim from the institutional provider, the insurer may also request additional reasonable relevant information within 30 calendar days of receipt of the emergency department report, at which time the claim shall be deemed complete. A claim from a professional provider shall be deemed complete upon submission of a completed HCFA 1500 or its electronic equivalent or other format adopted by the National Uniform Billing Committee, and reasonable relevant information requested by the insurer within 30 calendar days of receipt of the claim. The provider shall provide the insurer reasonable relevant information within 10 working days of receipt of a written request that is clear and specific regarding the information sought. If, as a result of reviewing the reasonable relevant information, the insurer requires further information, the insurer shall have an additional 15 calendar days after receipt of the reasonable relevant information to request the further information, notwithstanding any time limit to the contrary in this section, at which time the claim shall be deemed complete.

(d) This section shall not apply to claims about which there is evidence of fraud and misrepresentation, to eligibility determinations, or in instances where the plan has not been granted reasonable access to information under the provider's control. An insurer shall specify, in a written notice to the provider within 30 calendar days of receipt of the claim, which, if any, of these exceptions applies to a claim.

(e) If a claim or portion thereof is contested on the basis that the insurer has not received information reasonably necessary to determine payer liability for the claim or portion thereof, then the insurer shall have 30 calendar days after receipt of this additional information to complete reconsideration of the claim. If a claim, or portion thereof, undergoing reconsideration is not reimbursed by delivery to the claimant's address of record within the 30 calendar days after receipt of the additional information, the insurer shall pay interest at the rate of 15 percent per annum beginning with the first calendar day after the 30-calendar-day period. An insurer shall automatically include interest due in the payment made to the claimant, without requiring a request therefor.

(f) An insurer shall not delay payment on a claim from a physician or other provider to await the submission of a claim from a hospital or other provider, without citing specific rationale as to why the delay was necessary and providing a monthly update regarding the status of the claim and the insurer's actions to resolve the claim, to the provider that submitted the claim.

(g) An insurer shall not request or require that a provider waive its rights pursuant to this section.

(h) This section shall apply only to claims for services rendered to a patient who was provided emergency services and care as defined in Section 1317.1 of the Health and Safety Code in the United States on or after September 1, 1999.

(i) This section shall not be construed to affect the rights or obligations of any person pursuant to Section 10123.13.

(j) This section shall not be construed to affect a written agreement, if any, of a provider to submit bills within a specified time period.

(k) (1) The department may issue guidance and regulations relating to this section. The guidance and regulations shall not be subject to the rulemaking provisions of the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until December 31, 2027.

(2) After January 1, 2028, the department may issue regulations relating to this section subject to the rulemaking provisions of the Administrative Procedure Act ((Chapter 3.5 commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code) until December 31, 2030.

(l) This section shall become operative on January 1, 2026.

(Repealed (in Sec. 8) and added by Stats. 2024, Ch. 763, Sec. 9. (AB 3275) Effective January 1, 2025. Operative January 1, 2026, by its own provisions.)

10123.15. Every group policy of disability insurance which covers hospital, medical, and surgical expenses on a group basis, and which offers coverage for disorders of the brain shall also offer coverage in the same manner for the treatment of the following biologically based severe mental disorders: schizophrenia, schizo-affective disorder, bipolar disorders and delusional depressions, and pervasive developmental disorder. Coverage for these mental disorders shall be subject to the same terms and conditions applied to the treatment of other disorders of the brain; however, an insurer may reserve the right to confirm diagnoses and to review

the appropriateness of specific treatment plans as necessary to ensure that coverage under this section is provided for only those diagnostic and treatment services which are medically necessary.

Nothing in this section shall be construed to affect the scope of licensure of any health care professional nor to impair rights to reimbursement guaranteed health care providers pursuant to Section 10176.

(Amended by Stats. 1992, Ch. 462, Sec. 1. Effective January 1, 1993.)

10123.16. Except for a preexisting condition, every disability insurer issuing policies of individual or group disability insurance in this state that offers group or individual coverage for long-term care facility services or home-based care shall not exclude persons covered by the plan from receiving these benefits, if they are diagnosed as having any significant destruction of brain tissue with resultant loss of brain function, including, but not limited to, progressive, degenerative, and dementing illnesses, including, but not limited to, Alzheimer's disease, from the coverage offered for long-term care facility services or home-based care.

For purposes of this section, where a particular disease can be determined only with an autopsy, "diagnosed" means clinical diagnosis not dependent on pathological confirmation, but employing nationally accepted criteria.

(Amended by Stats. 1988, Ch. 1049, Sec. 2.)

10123.17. Except for a preexisting condition, every self-insured employee welfare benefit plan in this state that offers group coverage for long-term care facility services or home-based care shall not exclude persons covered by the plan from receiving these benefits, if they are diagnosed as having any significant destruction of brain tissue with resultant loss of brain function, including, but not limited to, progressive, degenerative, and dementing illnesses, including, but not limited to, Alzheimer's disease, from the coverage offered for long-term care facility services or home-based care.

For purposes of this section, where a particular disease can be determined only with an autopsy, "diagnosed" means clinical diagnosis not dependent on pathological confirmation, but employing nationally accepted criteria.

(Amended by Stats. 1988, Ch. 1049, Sec. 3.)

10123.18. (a) A disability insurance policy issued, amended, or renewed on or after January 1, 2024, and that provides coverage for hospital, medical, or surgical benefits shall provide coverage, upon the referral of a patient's physician and surgeon, a nurse practitioner, or a certified nurse-midwife, providing care to the patient and operating within the scope of practice otherwise permitted for the licensee, for an annual cervical cancer screening test.

(1) The coverage for an annual cervical cancer screening test provided pursuant to this section shall include the conventional Pap test, a human papillomavirus screening test that is approved by the United States Food and Drug Administration (FDA) and the option of any cervical cancer screening test approved by the FDA, upon the referral of the patient's health care provider.

(2) This subdivision does not require an individual or group policy to cover treatment or surgery for cervical cancer or to prevent application of deductible or copayment provisions contained in the policy or certificate, and does not require that coverage under an individual or group policy be extended to any other procedures.

(b) A disability insurance policy issued, amended, or renewed on or after January 1, 2024, that provides coverage for hospital, medical, or surgical benefits shall provide coverage for the human papillomavirus vaccine for insureds for whom the vaccine is approved by the FDA. The policy shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this subdivision.

(c) This section shall not apply to vision-only, dental-only, accident-only, specified disease, hospital indemnity, Medicare supplement, CHAMPUS supplement, long-term care, or disability income insurance. For accident-only, hospital indemnity, or specified disease insurance, coverage for benefits under this section shall apply only to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy or certificate. This section does not impose a new benefit mandate on accident-only, hospital indemnity, or specified disease insurance.

(Amended by Stats. 2023, Ch. 809, Sec. 7. (AB 659) Effective January 1, 2024.)

10123.184. (a) Every group policy of disability insurance that covers hospital, medical, or surgical expenses, and that provides maternity benefits, that is issued, amended, renewed, or delivered on or after January 1, 1999, and every individual policy of disability insurance that covers hospital, medical, or surgical expenses, and that provides maternity benefits, that is of a type and form first offered for sale on or after January 1, 1999, shall provide coverage for participation in the California Prenatal Screening Program, which is a statewide prenatal testing program administered by the State Department of Public Health, pursuant to Section 124977 of the Health and Safety Code. Notwithstanding any other law, a disability insurer that provides coverage for maternity benefits shall not require participation in the statewide prenatal testing program administered by the State Department of Public Health as a prerequisite to eligibility for, or receipt of, any other service.

(b) Coverage required under this section shall not be subject to copayment, coinsurance, deductible, or any other form of cost sharing.

(c) Reimbursement for services covered pursuant to this section shall be paid at the amount set pursuant to Section 124977 of the Health and Safety Code and regulations adopted thereunder.

(Amended by Stats. 2015, Ch. 18, Sec. 24. (SB 75) Effective June 24, 2015.)

10123.185. (a) Every policy of disability insurance that covers hospital, medical, or surgical expenses and is issued, amended, delivered, or renewed in this state and certificate of group disability insurance issued, amended, delivered, or renewed in this state pursuant to a master group policy issued, amended, delivered, or renewed in another state on or after January 1, 1994, shall be deemed to include coverage for services related to diagnosis, treatment, and appropriate management of osteoporosis. The services may include, but need not be limited to, all Food and Drug Administration approved technologies, including bone mass measurement technologies as deemed medically appropriate.

(b) This section shall not apply to specified accident, specified disease, hospital indemnity, Medicare supplement, or long-term care health insurance policies.

(Added by Stats. 1993, Ch. 1208, Sec. 3. Effective January 1, 1994.)

10123.19. (a) Any disability insurance policy that includes terms that require binding arbitration to settle disputes and that restrict, or provide for a waiver of, the right to a jury trial shall include, in clear and understandable language, a disclosure that meets all of the following conditions:

(1) The disclosure shall clearly state whether the plan uses binding arbitration to settle disputes, including specifically whether the plan uses binding arbitration to settle claims of medical malpractice.

(2) The disclosure shall appear as a separate article in the agreement issued to the employer group or individual subscriber and shall be prominently displayed on the enrollment form signed by each subscriber or enrollee.

(3) In any disability insurance policy, the disclosure required by this section shall be displayed immediately before the signature line provided for the representative of the group contracting with a disability insurer and immediately before the signature line provided for the individual enrolling in the policy.

(b) Any disability insurance policy that includes a term that requires the parties to submit to binding arbitration in case of a medical malpractice claim or dispute shall, for those cases or disputes for which the total amount of damages claimed is fifty thousand dollars ($50,000) or less, provide for selection by the parties of a single neutral arbitrator who shall have no jurisdiction to award more than fifty thousand dollars ($50,000). If the parties are unable to agree on the selection of a single neutral arbitrator, the method provided in Section 1281.6 of the Code of Civil Procedure shall be utilized.

The provision shall not be subject to waiver by the policy.

(Added by Stats. 1994, Ch. 653, Sec. 5. Effective January 1, 1995.)

10123.191. (a) Notwithstanding any other law, on and after January 1, 2013, a health insurer that provides coverage for prescription drugs shall utilize and accept only the prior authorization form developed pursuant to subdivision (c), or an electronic prior authorization process described in subdivision (e), when requiring prior authorization for prescription drugs.

(b) (1) If a health insurer, contracted physician group, or utilization review organization fails to notify a prescribing provider of its coverage determination within 72 hours for nonurgent requests, or within 24 hours if exigent circumstances exist, upon receipt of a completed prior authorization or step therapy exception request, the prior authorization or step therapy exception request shall be deemed approved for the duration of the prescription, including refills.

(2) If a request for prior authorization or a step therapy exception is incomplete or clinically relevant material information necessary to make a coverage determination is not included, the insurer, contracted physician group, or utilization review organization shall notify the prescribing provider within 72 hours of receipt, or within 24 hours of receipt if exigent circumstances exist, what additional or clinically relevant material information is needed to approve or deny the prior authorization or step therapy exception request, or to appeal the denial thereof. Once the requested information is received, the applicable time period to approve or deny a prior authorization or step therapy exception request, or to appeal, shall begin to elapse. If a coverage determination or request for additional or clinically relevant material information by an insurer, contracted physician group, or utilization review organization is not received by the prescribing provider within the time allotted, the prior authorization or step therapy exception request, or appeal of a denial thereof, shall be deemed approved for the duration of the prescription, including refills. In the event of a denial, the insurer, contracted physician group, or utilization review organization shall inform the prescribing provider and insured of the external appeal process under subdivision (h) of this section, which shall also apply to a denial of a prior authorization or step therapy exception request.

(3) A health insurer, contracted physician group, utilization review organization, or external independent review organization shall approve a step therapy exception request, or internal or external appeal of a denial thereof, if any of the criteria in subdivision (c) of Section 10123.201 are satisfied.

(c) On or before January 1, 2017, the department and the Department of Managed Health Care shall jointly develop a uniform prior authorization form. Notwithstanding any other law, on and after July 1, 2017, or six months after the form is completed pursuant to this section, whichever is later, every prescribing provider shall use that uniform prior authorization form, or an electronic prior authorization process described in subdivision (e), to request prior authorization for coverage of prescription drugs and every health insurer shall accept that form or electronic process as sufficient to request prior authorization for prescription drugs.

(d) The prior authorization form developed pursuant to subdivision (c) shall meet the following criteria:

(1) The form shall not exceed two pages.

(2) The form shall be made electronically available by the department and the health insurer.

(3) The completed form may also be electronically submitted from the prescribing provider to the health insurer.

(4) The department and the Department of Managed Health Care shall develop the form with input from interested parties from at least one public meeting.

(5) The department and the Department of Managed Health Care, in development of the standardized form, shall take into consideration the following:

(A) Existing prior authorization forms established by the federal Centers for Medicare and Medicaid Services and the State Department of Health Care Services.

(B) National standards pertaining to electronic prior authorization.

(e) A prescribing provider may use an electronic prior authorization system utilizing the standardized form described in subdivision (c) or an electronic process developed specifically for transmitting prior authorization information that meets the National Council for Prescription Drug Programs' SCRIPT standard for electronic prior authorization transactions.

(f) Subdivision (a) does not apply if any of the following occurs:

(1) A contracted physician group is delegated the financial risk for the pharmacy or medical drug benefit by a health insurer.

(2) A contracted physician group uses its own internal prior authorization process rather than the health insurer's prior authorization process for the health insurer's insureds.

(3) A contracted physician group is delegated a utilization management function by the health insurer concerning any prescription drug, regardless of the delegation of financial risk.

(g) For prescription drugs, prior authorization requirements described in subdivisions (c) and (e) apply regardless of how that benefit is classified under the terms of the health insurer's group or individual policy.

(h) A health insurer shall maintain a process for an external exception request review that complies with subdivision (c) of Section 156.122 of Title 45 of the Code of Federal Regulations. The external appeal process for exception requests shall also apply to a denial of a prior authorization or step therapy exception request. An independent review organization's reversal of a health insurer's denial of a request for an exception, prior authorization, or a step therapy exception shall be binding on the insurer and shall apply for the duration of the prescription, including refills. An insurer shall notify the insured and prescribing provider of the independent review organization's coverage determination, or request for additional or clinically relevant material information necessary to make a coverage determination, within the time limits required by paragraph (2) of subdivision (b). This subdivision shall not affect or limit an insured's eligibility for independent medical review under Section 10169 or to file an internal appeal with the insurer.

(i) For an individual, small group, or large group health insurance policy, a health insurer that provides coverage for prescription drugs shall comply with subdivision (c) of Section 156.122 of Title 45 of the Code of Federal Regulations.

(j) For purposes of this section:

(1) "Prescribing provider" shall include a provider authorized to write a prescription, pursuant to subdivision (a) of Section 4040 of the Business and Professions Code, to treat a medical condition of an insured.

(2) "Exigent circumstances" exist when an insured is suffering from a health condition that may seriously jeopardize the insured's life, health, or ability to regain maximum function or when an insured is undergoing a current course of treatment using a nonformulary drug.

(3) "Completed prior authorization request" means a completed uniform prior authorization form developed pursuant to subdivision (c), or a completed request submitted using an electronic prior authorization system described in subdivision (e), or, for contracted

physician groups described in subdivision (f), the process used by the contracted physician group.

(4) “Step therapy exception” means a decision to override a generally applicable step therapy protocol in favor of coverage of the prescription drug prescribed by a health care provider for an individual insured.

(Amended by Stats. 2021, Ch. 742, Sec. 4. (AB 347) Effective January 1, 2022.)

10123.192. (a) A health insurer that provides prescription drug benefits and maintains one or more drug formularies shall do all of the following:

(1) Post the formulary or formularies for each product offered by the insurer on the insurer’s Internet Web site in a manner that is accessible and searchable by potential insureds, insureds, providers, the general public, the department, and federal agencies as required by federal law or regulations.

(2) Update the formularies posted pursuant to paragraph (1) with any change to those formularies on a monthly basis.

(3) No later than six months after the date that a standard formulary template is developed under subdivision (b), use that template to display the formulary or formularies for each product offered by the insurer.

(b) (1) By January 1, 2017, the department and the Department of Managed Health Care shall jointly, and with input from interested parties from at least one public meeting, develop a standard formulary template for purposes of paragraph (3) of subdivision (a). In developing the template, the department and Department of Managed Health Care shall take into consideration existing requirements for reporting of formulary information established by the federal Centers for Medicare and Medicaid Services. To the extent feasible, in developing the template, the department and the Department of Managed Health Care shall evaluate a way to include on the template, in addition to the information required to be included under paragraph (2), cost-sharing information for drugs subject to coinsurance.

(2) The standard formulary template shall include a notification that the presence of a drug on the insurer’s formulary does not guarantee that an insured will be prescribed that drug by his or her prescribing provider for a particular medical condition. As applied to a particular formulary for a product offered by an insurer, the standard formulary template shall do all of the following:

(A) Include information on cost-sharing tiers and utilization controls, including prior authorization or step therapy requirements, for each drug covered by the product.

(B) Indicate any drugs on the formulary that are preferred over other drugs on the formulary.

(C) Include information to educate insureds about the differences between drugs administered or provided under a health insurer’s medical benefit and drugs prescribed under a health insurer’s prescription drug benefit and about how to obtain coverage information about drugs that are not covered under the health insurer’s prescription drug benefit.

(D) Include information to educate insureds that health insurers that provide prescription drug benefits are required to have a method for insureds to obtain prescription drugs not listed in the health insurer’s drug formulary if the drugs are deemed to be medically necessary by a clinician pursuant to Section 1367.24 of the Health and Safety Code, as required by clause (iv) of subparagraph (A) of paragraph (2) of subdivision (a) of Section 10112.27.

(E) Include information on which medications are covered, including both generic and brand name.

(F) Include information on what tier of the health insurer’s drug formulary each medication is in.

(c) The commissioner may adopt regulations as may be necessary to carry out the purposes of this section. In adopting regulations, the commissioner shall comply with Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) For purposes of this section, “formulary” means the complete list of drugs preferred for use and eligible for coverage under a health insurance product and includes the drugs covered under the pharmacy benefit of the product.

(Amended by Stats. 2015, Ch. 619, Sec. 6. (AB 339) Effective January 1, 2016.)

10123.193. (a) The Legislature hereby finds and declares all of the following:

(1) The federal Patient Protection and Affordable Care Act, its implementing regulations and guidance, and related state law prohibit discrimination based on a person’s expected length of life, present or predicted disability, degree of medical dependency,

quality of life, or other health conditions, including benefit designs that have the effect of discouraging the enrollment of individuals with significant health needs.

(2) The Legislature intends to build on the existing state and federal law to ensure that health coverage benefit designs do not have an unreasonable discriminatory impact on chronically ill individuals, and to ensure affordability of outpatient prescription drugs.

(3) Assignment of all or most prescription medications that treat a specific medical condition to the highest cost tiers of a formulary may effectively discourage enrollment by chronically ill individuals, and may result in lower adherence to a prescription drug treatment regimen.

(b) A nongrandfathered policy of health insurance that is offered, amended, or renewed on or after January 1, 2017, shall comply with this section. The cost-sharing limits established by this section apply only to outpatient prescription drugs covered by the policy that constitute essential health benefits, as defined by Section 10112.27.

(c) A policy of health insurance that provides coverage for outpatient prescription drugs shall cover medically necessary prescription drugs, including nonformulary drugs determined to be medically necessary consistent with this part.

(d) Copayments, coinsurance, and other cost sharing for outpatient prescription drugs shall be reasonable so as to allow access to medically necessary outpatient prescription drugs.

(e) (1) Consistent with federal law and guidance, the formulary or formularies for outpatient prescription drugs maintained by the health insurer shall not discourage the enrollment of individuals with health conditions and shall not reduce the generosity of the benefit for insureds with a particular condition in a manner that is not based on a clinical indication or reasonable medical management practices. Section 1342.7 of the Health and Safety Code and any regulations adopted pursuant to that section shall be interpreted in a manner that is consistent with this section.

(2) For combination antiretroviral drug treatments that are medically necessary for the treatment of AIDS/HIV, a policy of health insurance shall cover a single-tablet drug regimen that is as effective as a multitablet regimen unless, consistent with clinical guidelines and peer-reviewed scientific and medical literature, the multitablet regimen is clinically equally or more effective and more likely to result in adherence to a drug regimen.

(3) Any limitation or utilization management shall be consistent with and based on clinical guidelines and peer-reviewed scientific and medical literature.

(f) (1) This section shall not be construed to require a health insurer to impose cost sharing.

(2) This section shall not be construed to require cost sharing for prescription drugs that state or federal law otherwise requires to be provided without cost sharing.

(3) A prescription drug benefit shall provide that if the pharmacy's retail price for a prescription drug is less than the applicable copayment or coinsurance amount, the insured shall not be required to pay more than the retail price. The payment rendered shall constitute the applicable cost sharing and shall apply to the deductible, if any, and also to the maximum out-of-pocket limit in the same manner as if the enrollee had purchased the prescription medication by paying the cost-sharing amount.

(g) A policy of health insurance shall ensure that the placement of prescription drugs on formulary tiers is based on clinically indicated, reasonable medical management practices.

(h) In the provision of outpatient prescription drug coverage, a health insurer may utilize formulary, prior authorization, step therapy, or other reasonable medical management practices consistent with this part.

(Amended (as amended by Stats. 2016, Ch. 86, Sec. 204) by Stats. 2018, Ch. 787, Sec. 5. (SB 1021) Effective January 1, 2019.)

10123.1932. (a) (1) With respect to an individual or group policy of health insurance subject to Section 10112.28, the copayment, coinsurance, or any other form of cost sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days shall not exceed two hundred fifty dollars ($250), except as provided in paragraphs (2) and (3).

(2) With respect to products with actuarial value at or equivalent to the bronze level, cost sharing for a covered outpatient prescription drug for an individual prescription for a supply of up to 30 days shall not exceed five hundred dollars ($500), except as provided in paragraph (3).

(3) For a policy of health insurance that is a "high deductible health plan" under the definition set forth in Section 223(c)(2) of Title 26 of the United States Code, paragraphs (1) and (2) of this subdivision shall apply only once an insured's deductible has been satisfied for the year.

(4) For a nongrandfathered individual or small group policy of health insurance, the annual deductible for outpatient drugs, if any, shall not exceed twice the amount specified in paragraph (1) or (2), respectively.

(5) For purposes of paragraphs (1) and (2), “any other form of cost sharing” shall not include a deductible.

(6) A copayment or percentage coinsurance shall not exceed 50 percent of the cost to the insurer, as described in Section 1300.67.24 of Title 28 of the California Code of Regulations.

(7) If there is a generic equivalent to a brand name drug, an insurer shall ensure that the insured is subject to the lowest cost sharing that would be applied, whether or not both the generic equivalent and the brand name drug are on the formulary. This paragraph shall not be construed to require both the generic equivalent and the brand name drug to be on the formulary.

(b) (1) If a policy of health insurance offered, sold, or renewed in the nongrandfathered individual or small group market maintains a drug formulary grouped into tiers that includes a fourth tier, a policy of health insurance shall use the following definitions for each tier of the drug formulary:

(A) Tier one shall consist of most generic drugs and low-cost preferred brand name drugs.

(B) Tier two shall consist of nonpreferred generic drugs, preferred brand name drugs, and any other drugs recommended by the health insurer’s pharmacy and therapeutics committee based on safety, efficacy, and cost.

(C) Tier three shall consist of nonpreferred brand name drugs or drugs that are recommended by the health insurer’s pharmacy and therapeutics committee based on safety, efficacy, and cost, or that generally have a preferred and often less costly therapeutic alternative at a lower tier.

(D) Tier four shall consist of drugs that the Food and Drug Administration of the United States Department of Health and Human Services or the manufacturer requires to be distributed through a specialty pharmacy, drugs that require the insured to have special training or clinical monitoring for self-administration, or drugs that cost the health insurer more than six hundred dollars ($600) net of rebates for a one-month supply.

(2) In placing specific drugs on specific tiers, or choosing to place a drug on the formulary, the insurer shall comply with the other provisions of this section and this part.

(3) A policy of health insurance may maintain a drug formulary with fewer than four tiers. A policy of health insurance shall not maintain a drug formulary with more than four tiers.

(4) This section shall not be construed to limit a health insurer from placing any drug in a lower tier.

(Amended by Stats. 2023, Ch. 820, Sec. 2. (AB 948) Effective January 1, 2024.)

10123.1933. (a) (1) Notwithstanding Section 10123.201, a health insurer shall not subject antiretroviral drugs that are medically necessary for the prevention of AIDS/HIV, including preexposure prophylaxis or postexposure prophylaxis, to prior authorization or step therapy, except as provided in paragraph (2).

(2) If the United States Food and Drug Administration has approved one or more therapeutic equivalents of a drug, device, or product for the prevention of AIDS/HIV, this section does not require a health insurer to cover all of the therapeutically equivalent versions without prior authorization or step therapy, if at least one therapeutically equivalent version is covered without prior authorization or step therapy.

(b) Notwithstanding any other law, a health insurer shall not prohibit, or permit a contracted pharmacy benefit manager to prohibit, a pharmacist from dispensing preexposure prophylaxis or postexposure prophylaxis.

(c) A health insurer shall cover preexposure prophylaxis and postexposure prophylaxis that has been furnished by a pharmacist, as authorized in Sections 4052.02 and 4052.03 of the Business and Professions Code, including the pharmacist’s services and related testing ordered by the pharmacist. A health insurer shall pay or reimburse, consistent with the requirements of this chapter, for the service performed by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy if the health insurer has an out-of-network pharmacy benefit.

(Amended by Stats. 2024, Ch. 1, Sec. 3. (SB 339) Effective February 6, 2024.)

10123.1935. (a) Notwithstanding any other law, a group or individual health insurer offering an outpatient prescription drug benefit shall provide coverage for at least one medication approved by the United States Food and Drug Administration in each of the following categories without prior authorization, step therapy, or utilization review:

(1) Medication for the reversal of opioid overdose, including a naloxone product or another opioid antagonist.

(2) Medication for the detoxification or maintenance treatment of a substance use disorder, including a daily oral buprenorphine product.

(3) A long-acting buprenorphine product.

(4) A long-acting injectable naltrexone product.

(b) This section does not prohibit a health insurer from selecting an AB-rated generic equivalent, biosimilar, as defined in Section 262(i)(2) of Title 42 of the United States Code, or interchangeable biological product, as defined in Section 262(i)(3) of Title 42 of the United States Code, to meet the requirements of subdivision (a).

(Added by Stats. 2024, Ch. 633, Sec. 2. (AB 1842) Effective January 1, 2025.)

10123.194. (a) Every disability insurer that covers hospital, medical, or surgical expenses, and, as part of that coverage, also covers prescription drug benefits, and that issues a card to insureds for claims processing purposes, shall issue to each of its insureds a uniform card containing uniform prescription drug information. The uniform prescription drug information card shall, at a minimum, include the following information:

(1) The name or logo of the benefit administrator or disability insurer issuing the card, which shall be displayed on the front side of the card.

(2) The insured's identification number, or the policyholder's identification number when the insured is a dependent who accesses services using the policy holder's identification number, which shall be displayed on the front side of the card.

(3) A telephone number that pharmacy providers may call for assistance.

(4) Information required by the benefit administrator or disability insurer that is necessary to commence processing the pharmacy claim, except as provided for in paragraph (5).

(5) A disability insurer shall not be required to print any of the following information on an insured's card:

(A) Any number that is the same for all of its insured, provided that the disability insurer provides this number to the pharmacy on an annual basis.

(B) Any information that may result in fraudulent use of the card.

(C) Any information that is otherwise prohibited from being included on the card.

(b) Beginning July 1, 2002, the new uniform prescription drug information card required by subdivision (a) shall be issued by an insurer to an insured upon enrollment or upon any change in the insured's coverage that impacts the data content or format of the card.

(c) Nothing in this section requires an insurer to issue a separate card for prescription drug coverage if the insurer issues a card for health care coverage in general and the card is able to accommodate the information required by subdivision (a).

(d) "Card" as used in this section includes other technology that performs substantially the same function as a card.

(e) For purposes of this section, if a disability insurer delegates responsibility for issuing the uniform prescription drug information card to a contractor or agent, then the contract between the disability insurer and its contractor or agent shall require compliance with this section.

(Added by Stats. 2001, Ch. 622, Sec. 2. Effective January 1, 2002.)

10123.1945. (a) (1) A disability insurance policy issued, amended, renewed, or delivered on or after January 1, 2024, except for a grandfathered health plan or a qualifying health plan for a health savings account, shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on vasectomy services or procedures. For a qualifying health plan for a health savings account, an insurer shall establish the plan's cost sharing for vasectomy services and procedures at the minimum level necessary to preserve the insured's ability to claim tax-exempt contributions and withdrawals from the insured's health savings account under Internal Revenue Service laws, regulations, and guidance.

(2) An insurer shall not impose any restrictions or delays, including, but not limited to, prior authorization, on vasectomy services and procedures.

(3) Coverage with respect to an insured under this section shall be identical for an insured's covered spouse and covered nonspouse dependents.

(b) This section shall not be construed to deny or restrict in any way an existing right or benefit provided under law or by contract.

(c) This section shall not be construed to require an individual or group disability insurance policy to cover experimental or investigational treatments.

(d) Notwithstanding any other provision of this section, a religious employer may request a disability insurance policy without coverage for contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, a disability insurance policy shall be provided without coverage for vasectomy services and procedures. The exclusion from coverage under this provision shall not apply to vasectomy services or procedures for purposes other than contraception.

(1) An insurer that contracts with a religious employer to provide a disability insurance policy that does not include coverage and benefits for vasectomy services and procedures shall notify, in writing, upon initial enrollment and annually thereafter upon renewal, each enrollee that vasectomy services and procedures are not included in the insured's disability insurance policy.

(2) For purposes of this section, a "religious employer" is an entity for which each of the following is true:

(A) The inculcation of religious values is the purpose of the entity.

(B) The entity primarily employs persons who share the religious tenets of the entity.

(C) The entity serves primarily persons who share the religious tenets of the entity.

(D) The entity is a nonprofit organization pursuant to Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(e) This section only applies to disability insurance policies or contracts that are defined as health benefit plans pursuant to subdivision (a) of Section 10198.6, except that for accident only, specified disease, or hospital indemnity coverage, coverage for benefits under this section applies to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy or contract. This section shall not be construed as imposing a new benefit mandate on accident only, specified disease, or hospital indemnity insurance.

(f) For purposes of this section, the following definitions apply:

(1) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.

(2) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(Added by Stats. 2022, Ch. 630, Sec. 16. (SB 523) Effective January 1, 2023.)

10123.195. (a) No group or individual disability insurance policy issued, delivered, or renewed in this state or certificate of group disability insurance issued, delivered, or renewed in this state pursuant to a master group policy issued, delivered, or renewed in another state that, as a provision of hospital, medical, or surgical services, directly or indirectly covers prescription drugs shall limit or exclude coverage for a drug on the basis that the drug is prescribed for a use that is different from the use for which that drug has been approved for marketing by the federal Food and Drug Administration (FDA), provided that all of the following conditions have been met:

(1) The drug is approved by the FDA.

(2) (A) The drug is prescribed by a contracting licensed health care professional for the treatment of a life-threatening condition; or

(B) The drug is prescribed by a contracting licensed health care professional for the treatment of a chronic and seriously debilitating condition, the drug is medically necessary to treat that condition, and the drug is on the insurer's formulary, if any.

(3) The drug has been recognized for treatment of that condition by any of the following:

(A) The American Hospital Formulary Service's Drug Information.

(B) One of the following compendia, if recognized by the federal Centers for Medicare and Medicaid Services as part of an anticancer chemotherapeutic regimen:

(i) The Elsevier Gold Standard's Clinical Pharmacology.

(ii) The National Comprehensive Cancer Network Drug and Biologics Compendium.

(iii) The Thomson Micromedex DrugDex.

(C) Two articles from major peer reviewed medical journals that present data supporting the proposed off-label use or uses as generally safe and effective unless there is clear and convincing contradictory evidence presented in a major peer reviewed medical journal.

(b) It shall be the responsibility of the contracting prescriber to submit to the insurer documentation supporting compliance with the requirements of subdivision (a), if requested by the insurer.

(c) Any coverage required by this section shall also include medically necessary services associated with the administration of a drug subject to the conditions of the contract.

(d) For purposes of this section, “life-threatening” means either or both of the following:

(1) Diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted.

(2) Diseases or conditions with potentially fatal outcomes, where the end point of clinical intervention is survival.

(e) For purposes of this section, “chronic and seriously debilitating” means diseases or conditions that require ongoing treatment to maintain remission or prevent deterioration and cause significant long-term morbidity.

(f) The provision of drugs and services when required by this section shall not, in itself, give rise to liability on the part of the insurer.

(g) This section shall not apply to a policy of disability insurance that covers hospital, medical, or surgical expenses which is issued outside of California to an employer whose principal place of business is located outside of California.

(h) Nothing in this section shall be construed to prohibit the use of a formulary, copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA.

(i) If an insurer denies coverage pursuant to this section on the basis that its use is experimental or investigational, that decision is subject to review under the Independent Medical Review System of Article 3.5 (commencing with Section 10169).

(j) This section is not applicable to vision-only, dental-only, Medicare or Champus supplement, disability income, long-term care, accident-only, specified disease or hospital confinement indemnity insurance.

(Amended by Stats. 2009, Ch. 479, Sec. 3. (AB 830) Effective January 1, 2010.)

10123.196. (a) An individual or group policy of disability insurance issued, amended, renewed, or delivered on or after January 1, 2000, through December 31, 2015, inclusive, that provides coverage for hospital, medical, or surgical expenses, shall provide coverage for the following, under the same terms and conditions as applicable to all benefits:

(1) A disability insurance policy that provides coverage for outpatient prescription drug benefits shall include coverage for a variety of federal Food and Drug Administration (FDA)-approved prescription contraceptive methods, as designated by the insurer. If an insured’s health care provider determines that none of the methods designated by the disability insurer is medically appropriate for the insured’s medical or personal history, the insurer shall, in the alternative, provide coverage for some other FDA-approved prescription contraceptive method prescribed by the patient’s health care provider.

(2) Coverage with respect to an insured under this subdivision shall be identical for an insured’s covered spouse and covered nonspouse dependents.

(b) (1) A group or individual policy of disability insurance, except for a specialized health insurance policy, that is issued, amended, renewed, or delivered on or after January 1, 2016, shall provide coverage for all of the following services and contraceptive methods for all policyholders and insureds:

(A) (i) Except as provided in clause (ii) and in subparagraphs (B) and (C) of paragraph (2), all FDA-approved, contraceptive drugs, devices, and other products, including all FDA-approved, contraceptive drugs, devices, and products available over the counter, as prescribed by the insured’s provider.

(ii) For any policy described in paragraph (1) that is issued, amended, renewed, or delivered on or after January 1, 2024, both of the following conditions shall apply:

(I) A prescription shall not be required to trigger coverage of over-the-counter FDA-approved contraceptive drugs, devices, and products.

(II) Point-of-sale coverage for over-the-counter FDA-approved contraceptive drugs, devices, and products shall be provided at in-network pharmacies without cost sharing or medical management restrictions.

(B) Voluntary tubal ligation and other similar sterilization procedures.

(C) Clinical services related to the provision or use of contraception, including consultations, examinations, procedures, device insertion, ultrasound, anesthesia, patient education, referrals, and counseling.

(D) Followup services related to the drugs, devices, products, and procedures covered under this subdivision, including, but not limited to, management of side effects, counseling for continued adherence, and device removal.

(2) (A) Except for a grandfathered health plan, a disability insurer subject to this subdivision shall not impose a deductible, coinsurance, copayment, or any other cost-sharing requirement on the coverage provided pursuant to this subdivision.

(B) If the FDA has approved one or more therapeutic equivalents, as that term is defined by the FDA, of a contraceptive drug, device, or product, a disability insurer is not required to cover all of those therapeutically equivalent versions in accordance with this subdivision, as long as at least one is covered without cost sharing in accordance with this subdivision. If there is no therapeutically equivalent generic substitute available in the market, an insurer shall provide coverage without cost sharing for the original, brand name contraceptive.

(C) If a covered therapeutic equivalent of a drug, device, or product is deemed medically inadvisable by the insured's provider, a disability insurer shall defer to the determination and judgment of the provider and provide coverage for the alternative prescribed contraceptive drug, device, product, or service without imposing any cost-sharing requirements. Medical inadvisability may include considerations such as severity of side effects, differences in permanence or reversibility of contraceptives, and ability to adhere to the appropriate use of the drug or item, as determined by the provider. The department may promulgate regulations establishing an easily accessible, transparent, and sufficiently expedient process that is not unduly burdensome, including timeframes, for an insured, an insured's designee, or an insured's provider to request coverage of an alternative prescribed contraceptive. A request for coverage under this subparagraph that is submitted by an insured, an insured's designee, or a provider shall be approved by the disability insurer in compliance with the time limits in Section 10123.191.

(3) Except as otherwise authorized under this section, an insurer shall not infringe upon an insured's choice of contraceptive drug, device, or product and shall not impose any restrictions or delays on the coverage required under this subdivision, including prior authorization, step therapy, or other utilization control techniques.

(4) Coverage with respect to an insured under this subdivision shall be identical for an insured's covered spouse and covered nonspouse dependents.

(c) This section shall not be construed to deny or restrict in any way any existing right or benefit provided under law or by contract.

(d) This section shall not be construed to require an individual or group disability insurance policy to cover experimental or investigational treatments.

(e) (1) Notwithstanding any other provision of this section, a religious employer may request a disability insurance policy without coverage for contraceptive methods that are contrary to the religious employer's religious tenets. If so requested, a disability insurance policy shall be provided without coverage for contraceptive methods. The exclusion from coverage under this provision shall not apply to a contraceptive drug, device, procedure, or other product that is used for purposes other than contraception.

(2) For purposes of this section, a "religious employer" is an entity for which each of the following is true:

(A) The inculcation of religious values is the purpose of the entity.

(B) The entity primarily employs persons who share the religious tenets of the entity.

(C) The entity serves primarily persons who share the religious tenets of the entity.

(D) The entity is a nonprofit organization pursuant to Section 6033(a)(3)(A)(i) or (iii) of the Internal Revenue Code of 1986, as amended.

(f) (1) A group or individual policy of disability insurance, except for a specialized health insurance policy, that is issued, amended, renewed, or delivered on or after January 1, 2017, shall cover up to a 12-month supply of FDA-approved, self-administered hormonal contraceptives when dispensed or furnished at one time for an insured by a provider, pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies.

(2) This subdivision shall not be construed to require a policy to cover contraceptives provided by an out-of-network provider, pharmacy, or location licensed or otherwise authorized to dispense drugs or supplies, except as may be otherwise authorized by state or federal law or by the insurer's policies governing out-of-network coverage.

(3) This subdivision shall not be construed to require a provider to prescribe, furnish, or dispense 12 months of self-administered hormonal contraceptives at one time.

(4) An insurer subject to this subdivision shall not impose utilization controls or other forms of medical management limiting the supply of FDA-approved, self-administered hormonal contraceptives that may be dispensed or furnished by a provider or pharmacist, or at a location licensed or otherwise authorized to dispense drugs or supplies to an amount that is less than a 12-month supply, and shall not require an insured to make any formal request for such coverage other than a pharmacy claim.

(g) This section shall not be construed to exclude coverage for contraceptive supplies as prescribed by a provider, acting within the provider's scope of practice, for reasons other than contraceptive purposes, such as decreasing the risk of ovarian cancer or eliminating symptoms of menopause, or for contraception that is necessary to preserve the life or health of an insured.

(h) This section only applies to disability insurance policies or contracts that are defined as health benefit plans pursuant to subdivision (a) of Section 10198.6, except that for accident only, specified disease, or hospital indemnity coverage, coverage for benefits under this section applies to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy or contract. This section shall not be construed as imposing a new benefit mandate on accident only, specified disease, or hospital indemnity insurance.

(i) For purposes of this section, the following definitions apply:

(1) "Grandfathered health plan" has the meaning set forth in Section 1251 of PPACA.

(2) "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued thereunder.

(3) With respect to policies of disability insurance issued, amended, or renewed on or after January 1, 2016, "health care provider" means an individual who is certified or licensed to furnish family planning services within their scope of practice pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code, including a pharmacist authorized pursuant to Section 4052 or 4052.3 of the Business and Professions Code, or an initiative act referred to in that division, or Division 2.5 (commencing with Section 1797) of the Health and Safety Code.

(4) For purposes of this section, "over-the-counter FDA-approved contraceptive drugs, devices, and products" and "over-the-counter birth control methods" are limited to those included as essential health benefits pursuant to Section 10112.27.

(Amended by Stats. 2022, Ch. 630, Sec. 17. (SB 523) Effective January 1, 2023.)

10123.1961. (a) (1) The requirements of this section shall apply to a group or individual policy or certificate of health insurance or student blanket disability insurance that provides coverage for hospital, medical, or surgical expenses that is issued, amended, renewed, or delivered on or after January 1, 2023. This section does not apply to a specialized health insurance policy. A policy or certificate subject to the requirements of this section shall not impose a deductible, coinsurance, copayment, or other cost-sharing requirement on coverage for all abortion and abortion-related services, including preabortion and followup services.

(2) Except as otherwise authorized by this section, an insurer shall not impose any utilization management or utilization review, including prior authorization and annual or lifetime limits consistent with Sections 10112.1 and 10112.27, on the coverage for outpatient abortion services.

(b) This section does not deny or restrict in any way the department's authority to ensure an insurer's compliance with this chapter when the insurer provides coverage for abortion services.

(c) This section does not require an individual or group disability insurance policy to cover an experimental or investigational treatment.

(d) For purposes of this section, "abortion" means any medical treatment intended to induce the termination of a pregnancy except for the purpose of producing a live birth.

(e) For a group or individual policy or certificate of health insurance or student blanket disability insurance that is a high deductible health plan, as defined in Section 223(c)(2) of Title 26 of the United States Code, the cost-sharing limits in paragraph (1) of subdivision (a) shall apply once an insured's deductible has been satisfied for the benefit year.

(f) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the commissioner may interpret and implement this section by issuing guidance without taking any further regulatory action. The commissioner shall consult with the Department of Managed Health Care in issuing guidance under this section. The department shall adopt regulations on or before January 1, 2026, in accordance with the requirements of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(Added by Stats. 2022, Ch. 11, Sec. 2. (SB 245) Effective January 1, 2023.)

10123.197. (a) A request for an exception to a health insurer's step therapy process for prescription drugs may be submitted in the same manner as a request for prior authorization for prescription drugs pursuant to Section 10123.191, and shall be treated in the

same manner, and shall be responded to by the health insurer in the same manner, as a request for prior authorization for prescription drugs.

(b) The department and the Department of Managed Health Care shall include a provision for step therapy exception requests in the uniform prior authorization form developed pursuant to subdivision (c) of Section 10123.191.

(c) “Step therapy exception” means a decision to override a generally applicable step therapy protocol in favor of coverage of the prescription drug prescribed by a health care provider for an individual insured.

(Amended by Stats. 2021, Ch. 742, Sec. 5. (AB 347) Effective January 1, 2022.)

10123.198. (a) On and after July 1, 2011, in accordance with the requirements of subdivision (b), a health insurer that provides coverage for professional mental health services shall issue an identification card to an insured in order to assist the insured with accessing health benefits coverage information, including, but not limited to, in-network provider access information, and claims processing purposes. The identification card, at a minimum, shall include all of the following information:

(1) The name of the health insurer issuing the identification card.

(2) The insured’s identification number.

(3) A telephone number that insureds or providers may call for assistance with health benefits coverage information, in-network provider access information, and claims processing information, and if assessment services are provided by the health insurer, access to assessment services for the purpose of referral to an appropriate level of care or an appropriate health care provider.

(4) The health insurer’s Internet Web site address.

(b) The identification card required by this section shall be issued by a health insurer to an insured upon commencement of coverage or upon a change in the insured’s coverage that impacts the data content or format of the card.

(c) This section does not require a health insurer to issue a separate identification card for professional mental health coverage if the insurer issues a card for health care coverage in general and the card provides the information required by this section.

(d) If a health insurer, as described in subdivision (a), delegates responsibility for issuing the card to a contractor or agent, the contractor or agent shall be required to comply with this section.

(e) This section does not prohibit a health insurer from meeting the standards of the Workgroup for Electronic Data Interchange (WEDI) or other national uniform standards with respect to identification cards, and a health insurer shall be deemed compliant with this section if the insurer conforms with these standards, as long as the minimum requirements described in subdivision (a) have been met.

(f) For the purposes of this section, “identification card” includes other technology that performs substantially the same function as an identification card.

(g) (1) This section shall not apply to Medicare supplement insurance, employee assistance programs, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance. This section shall also not apply to specialized health insurance policies, except behavioral health-only policies.

(2) Notwithstanding paragraph (1), this section shall not apply to a behavioral health-only policy that provides coverage for professional mental health services pursuant to a contract with a health care service plan or insurer if that plan or insurer issues an identification card to its subscribers or insureds pursuant to this section or Section 1367.29 of the Health and Safety Code.

(Amended by Stats. 2018, Ch. 687, Sec. 9. (SB 910) Effective January 1, 2019.)

10123.199. (a) A health insurer that provides coverage for professional mental health services shall establish an Internet Web site. Each Internet Web site shall include, or provide a link to, the following information:

(1) A telephone number that the insured or provider can call, during normal business hours, for assistance obtaining mental health benefits coverage information, including the extent to which benefits have been exhausted, in-network provider access information, and claims processing information.

(2) A link to prescription drug formularies posted pursuant to Section 10123.192, or instructions on how to obtain formulary information.

(3) A detailed summary description of the process by which the insurer reviews and approves, modifies, or denies requests for health care services as described in Section 10123.135.

(4) Lists of providers or instructions on how to obtain a provider list as required by Section 10133.1.

(5) A detailed summary of the health insurer's grievance process.

(6) A detailed description of how the insured may request continuity of care as described in Section 10133.55.

(7) Information concerning the right, and applicable procedure, of the insured to request an independent medical review pursuant to Section 10169.

(b) Except as otherwise specified, the material described in subdivision (a) shall be updated at least quarterly.

(c) The information described in subdivision (a) may be made available through a secured Internet Web site that is only accessible to the insured.

(d) The material described in subdivision (a) shall also be made available to insureds in hard copy upon request.

(e) This article does not preclude an insurer from including additional information on its Internet Web site for applicants or insureds, including, but not limited to, the cost of procedures or services by health care providers in an insurer's network.

(f) The department shall include on the department's Internet Web site, a link to the Internet Web site of each health insurer described in subdivision (a).

(g) This section shall not apply to Medicare supplement insurance, employee assistance programs, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, and specified disease insurance. This section shall also not apply to specialized health insurance policies, except behavioral health-only policies.

(h) This section shall not apply to a health insurer that contracts with a specialized health care service plan, insurer, or other entity to cover professional mental health services for its insureds, provided that the health insurer provides a link on its Internet Web site to an Internet Web site operated by the specialized health care service plan, insurer, or other entity with which it contracts, and that plan, insurer, or other entity complies with this section or Section 1368.016 of the Health and Safety Code.

(Amended by Stats. 2018, Ch. 687, Sec. 10. (SB 910) Effective January 1, 2019.)

10123.1991. (a) (1) An insurer shall provide to insureds a written or electronic notice regarding the benefits of a behavioral health and wellness screening for children and adolescents 8 to 18 years of age.

(2) "Behavioral health and wellness screening" means a screening, test, or assessment to identify indicators or symptoms of behavioral health issues in an individual, including, but not limited to, depression or anxiety.

(b) The notice shall provide information regarding the benefits of behavioral health and wellness screenings for both depression and anxiety.

(c) An insurer shall provide notice pursuant to this section annually.

(d) This section does not apply to Medi-Cal managed care that contracts with the State Department of Health Care Services entered into pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(Added by Stats. 2024, Ch. 200, Sec. 2. (AB 2556) Effective January 1, 2025.)

10123.20. (a) A health insurance policy that is issued, amended, delivered, or renewed on or after July 1, 2000, shall be deemed to provide coverage for all generally medically accepted cancer screening tests, subject to all other terms and conditions that would otherwise apply.

(b) A health insurance policy that is issued, amended, delivered, or renewed on or after July 1, 2022, shall not require prior authorization for either of the following:

(1) Biomarker testing for an insured with advanced or metastatic stage 3 or 4 cancer.

(2) Biomarker testing of cancer progression or recurrence in the insured with advanced or metastatic stage 3 or 4 cancer.

(c) For purposes of this section, "biomarker test" means a diagnostic test, such as single or multigene, of the cancer patient's biospecimen, such as tissue, blood, or other bodily fluids, for DNA or RNA alterations, including phenotypic characteristics of a malignancy, to identify an individual with a subtype of cancer, in order to guide patient treatment.

(d) This section shall not apply to vision-only, dental-only, accident-only, specified disease, hospital indemnity, Medicare supplement, long-term care, or disability income insurance, except that for accident-only, specified disease, or hospital indemnity insurance, coverage for benefits under this section shall apply to the extent that the benefits are covered under the general terms and conditions that apply to all other benefits under the policy or contract. This section shall not be construed as imposing a new benefit mandate on accident-only, specified disease, or hospital indemnity insurance.

(e) Notwithstanding subdivision (b), this section does not prohibit a health insurer from requiring prior authorization on biomarker testing that is not for an FDA-approved therapy for advanced or metastatic stage 3 or 4 cancer.

(f) This section does not limit, prohibit, or modify an insured's rights to biomarker testing as part of an approved clinical trial under Section 10145.4.

(Amended by Stats. 2021, Ch. 605, Sec. 2. (SB 535) Effective January 1, 2022.)

10123.201. (a) A policy of health insurance that covers outpatient prescription drugs shall cover medically necessary drugs. The policy may provide for step therapy and prior authorization consistent with Section 1342.7 of the Health and Safety Code and any regulations adopted pursuant to that section.

(b) (1) Commencing January 1, 2017, an insurer shall maintain a pharmacy and therapeutics committee that shall be responsible for developing, maintaining, and overseeing any drug formulary list. If the insurer delegates responsibility for the formulary to any entity, the obligation of the insurer to comply with this part shall not be waived.

(2) The pharmacy and therapeutics committee board membership shall conform with both of the following:

(A) Represent a sufficient number of clinical specialties to adequately meet the needs of insureds.

(B) Consist of a majority of individuals who are practicing physicians, practicing pharmacists, and other practicing health professionals who are licensed to prescribe drugs.

(3) Members of the board shall abstain from voting on any issue in which the member has a conflict of interest with respect to the issuer or a pharmaceutical manufacturer.

(4) At least 20 percent of the board membership shall not have a conflict of interest with respect to the issuer or any pharmaceutical manufacturer.

(5) The pharmacy and therapeutics committee shall meet at least quarterly and shall maintain written documentation of the rationale for its decisions regarding the development of, or revisions to, the formulary drug list.

(6) The pharmacy and therapeutics committee shall do all of the following:

(A) Develop and document procedures to ensure appropriate drug review and inclusion.

(B) Base clinical decisions on the strength of the scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other related information.

(C) Consider the therapeutic advantages of drugs in terms of safety and efficacy when selecting formulary drugs.

(D) Review policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange.

(E) Evaluate and analyze treatment protocols and procedures related to the insurer's formulary at least annually.

(F) Review and approve all clinical prior authorization criteria, step therapy protocols, and quantity limit restrictions applied to each covered drug.

(G) Review new United States Food and Drug Administration-approved drugs and new uses for existing drugs.

(H) Ensure the insurer's formulary drug list or lists cover a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states and does not discourage enrollment by any group of insureds.

(I) Ensure the insurer's formulary drug list or lists provide appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.

(7) This subdivision shall be interpreted consistent with federal guidance issued under paragraph (3) of subdivision (a) of Section 156.122 of Title 45 of the Code of Federal Regulations. This subdivision shall apply to the individual, small group, and large group markets.

(c) (1) A health insurer may impose prior authorization requirements on prescription drug benefits, consistent with the requirements of this part.

(2) (A) If there is more than one drug that is clinically appropriate for the treatment of a medical condition, a health insurer may require step therapy.

(B) A health insurer shall expeditiously grant a request for a step therapy exception within the applicable time limit required by Section 10123.191 if a prescribing provider submits necessary justification and supporting clinical documentation supporting the provider's determination that the required prescription drug is inconsistent with good professional practice for provision of medically necessary covered services to the insured, taking into consideration the insured's needs and medical history, along with the professional judgment of the insured's provider. The basis of the provider's determination may include, but is not limited to, any of the following criteria:

(i) The required prescription drug is contraindicated or is likely, or expected, to cause an adverse reaction or physical or mental harm to the insured in comparison to the requested prescription drug, based on the known clinical characteristics of the insured and the known characteristics and history of the insured's prescription drug regimen.

(ii) The required prescription drug is expected to be ineffective based on the known clinical characteristics of the insured and the known characteristics and history of the insured's prescription drug regimen.

(iii) The insured has tried the required prescription drug while covered by their current or previous health coverage or Medicaid, and that prescription drug was discontinued due to lack of efficacy or effectiveness, diminished effect, or an adverse reaction. The health insurer may require the submission of documentation demonstrating that the insured tried the required prescription drug before it was discontinued.

(iv) The required prescription drug is not clinically appropriate for the insured because the required drug is expected to do any of the following, as determined by the insured's prescribing provider:

(I) Worsen a comorbid condition.

(II) Decrease the capacity to maintain a reasonable functional ability in performing daily activities.

(III) Pose a significant barrier to adherence to, or compliance with, the insured's drug regimen or plan of care.

(v) The insured is stable on a prescription drug selected by the insured's prescribing provider for the medical condition under consideration while covered by their current or previous health coverage or Medicaid.

(C) (i) This section does not prohibit a health care provider from prescribing a prescription drug that is clinically appropriate.

(ii) This section does not prohibit an insurer or utilization review organization from requiring an insured to try an AB-rated generic equivalent, biosimilar, as defined in Section 262(i)(2) of Title 42 of the United States Code, or interchangeable biological product, as defined in Section 262(i)(3) of Title 42 of the United States Code, before providing coverage for the equivalent branded prescription drug.

(iii) Clause (ii) does not prohibit or supersede a step therapy exception request as described in subparagraph (B) of paragraph (2) of subdivision (c).

(3) An insurer shall provide coverage for the medically necessary dosage and quantity of the drug prescribed for the treatment of a medical condition consistent with professionally recognized standards of practice.

(4) For plan years commencing on or after January 1, 2017, an insurer that provides essential health benefits shall allow an insured to access prescription drug benefits at an in-network retail pharmacy unless the prescription drug is subject to restricted distribution by the United States Food and Drug Administration or requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy. A nongrandfathered individual or small group health insurer may charge an insured a different cost sharing for obtaining a covered drug at a retail pharmacy, but all cost sharing shall count toward the policy's annual limitation on cost sharing consistent with Section 10112.28.

(d) A health care provider or prescribing provider may file an internal appeal of a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request consistent with the health insurer's current utilization management processes.

(e) An insured or the insured's designee or guardian may appeal a denial of an exception request for coverage of a nonformulary drug, prior authorization request, or step therapy exception request by filing an internal appeal with the health insurer pursuant to Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations issued thereunder.

(f) Every health insurer that provides prescription drug benefits shall maintain all of the following information, which shall be made available to the commissioner upon request:

(1) The complete drug formulary or formularies of the insurer, if the insurer maintains a formulary, including a list of the prescription drugs on the formulary of the insurer by major therapeutic category with an indication of whether any drugs are preferred over other drugs.

(2) Records developed by the pharmacy and therapeutics committee of the insurer, or by others responsible for developing, modifying, and overseeing formularies, including medical groups, individual practice associations, and contracting pharmaceutical benefit management companies, used to guide the drugs prescribed for the insureds of the insurer, that fully describe the reasoning behind formulary decisions.

(3) Any insurer arrangements with prescribing providers, medical groups, individual practice associations, pharmacists, contracting pharmaceutical benefit management companies, or other entities that are associated with activities of the insurer to encourage formulary compliance or otherwise manage prescription drug benefits.

(g) If an insurer provides prescription drug benefits, the commissioner shall, as part of its market conduct examination, review the performance of the insurer in providing those benefits, including, but not limited to, a review of the procedures and information maintained pursuant to this section, and describe the performance of the insurer as part of its report issued as part of its market conduct examination.

(h) The commissioner shall not publicly disclose any information reviewed pursuant to this section that is determined by the commissioner to be confidential pursuant to state law.

(i) For purposes of this section, the following definitions shall apply:

(1) “Authorization” means approval by the health insurer to provide payment for the prescription drug.

(2) “Step therapy” means a type of protocol that specifies the sequence in which different prescription drugs for a given medical condition and medically appropriate for a particular patient are to be prescribed.

(3) “Step therapy exception” means a decision to override a generally applicable step therapy protocol in favor of coverage of the prescription drug prescribed by a health care provider for an individual insured.

(4) “Utilization review organization” means an entity that conducts utilization review, other than a health insurer performing its own utilization review.

(j) Nonformulary prescription drugs shall include any drug for which an insured’s copayment or out-of-pocket costs are different than the copayment for a formulary prescription drug, except as otherwise provided by law or regulation.

(k) This section does not affect an insured’s or policyholder’s eligibility to submit a complaint to the department for review or to apply to the department for an independent medical review under Article 3.5 (commencing with Section 10169).

(l) This section does not restrict or impair the application of any other provision of this part.

(m) This section and Section 10123.191 apply to both the health insurer and a utilization review organization that performs utilization review or utilization management functions on the insurer’s behalf. Commencing January 1, 2022, a contract between a health insurer and a utilization review organization that performs utilization review or utilization management functions on the insurer’s behalf shall include terms that require the utilization review organization to comply with this section and Section 10123.191.

(Amended by Stats. 2023, Ch. 495, Sec. 2. (SB 621) Effective January 1, 2024.)

10123.202. (a) A health insurance policy issued, amended, renewed, or delivered on or after January 1, 2017, excluding specialized health insurance policies, shall be prohibited from requiring an insured to receive a referral before receiving coverage or services for reproductive and sexual health care.

(b) (1) For the purposes of this section, “reproductive and sexual health care services” are all reproductive and sexual health services described in Sections 6925, 6926, 6927, and 6928 of the Family Code, or Section 121020 of the Health and Safety Code, obtained by a patient.

(2) This section applies whether or not the patient is a minor.

(c) In implementing this section, a health insurer may establish reasonable provisions governing utilization protocols for obtaining reproductive and sexual health care services, as provided for in subdivision (a), if these provisions are consistent with the intent of this section and are those customarily applied to other health care providers, such as primary care physicians and surgeons, to whom the insured has direct access, and are not more restrictive for reproductive and sexual health care services. An insured shall not be required to obtain prior approval from another physician, another provider, or the insurer before obtaining direct access to

reproductive and sexual health care services. An insurer may establish reasonable provisions governing communication with the insured's primary care physician and surgeon regarding the insured's condition, treatment, and a need for followup care.

(d) This section shall not apply to a health insurance policy that does not require insureds to obtain a referral from their primary care physician before seeking covered health care services from a specialist.

(e) A health insurer shall not impose utilization protocols related to contraceptive drugs, supplies, and devices beyond those in Section 10123.196.

(f) This section shall not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRICARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance.

(Amended by Stats. 2018, Ch. 687, Sec. 11. (SB 910) Effective January 1, 2019.)

10123.203. Commencing January 1, 2019, an insurer shall prorate an insured's cost sharing for a partial fill of a prescription dispensed pursuant to Section 4052.10 of the Business and Professions Code. This section shall only apply to oral, solid dosage forms of prescription drugs.

(Added by Stats. 2017, Ch. 615, Sec. 6. (AB 1048) Effective January 1, 2018.)

10123.204. (a) A health insurance policy issued, amended, delivered, or renewed on or after July 1, 2023, that provides prescription drug benefits and maintains one or more drug formularies shall do all of the following:

(1) Upon request of an insured or an insured's prescribing provider, furnish all of the following information regarding a prescription drug to the insured or the insured's prescribing health care provider:

(A) The insured's eligibility for the prescription drug.

(B) The most current formulary or formularies.

(C) Cost-sharing information for the prescription drug and other formulary alternatives, consistent with cost-sharing requirements as set forth in the policy and accurate at the time it is provided, including any variance in cost sharing based on the patient's preferred dispensing pharmacy, whether retail or mail order, or the health care provider.

(D) Applicable utilization management requirements for the prescription drug and other formulary alternatives.

(2) Respond in real time to a request made pursuant to paragraph (1) through a standard API.

(3) Allow the use of an interoperability element to provide the information required pursuant to paragraph (1).

(4) Ensure that the information provided pursuant to paragraph (1) is current no later than one business day after a change is made and is provided in real time.

(5) Provide the information pursuant to paragraph (1) if the request is made using the drug's unique billing code and National Drug Code.

(b) A health insurer shall not do any of the following:

(1) Deny or delay a response to a request for the purpose of blocking the release of information pursuant to subdivision (a).

(2) Restrict, prohibit, or otherwise hinder a prescribing provider from communicating or sharing to an insured any of the following:

(A) The information provided pursuant to subdivision (a).

(B) Additional information on any lower cost or clinically appropriate alternative drugs, whether or not they are covered under the insured's health insurance policy.

(C) Information about the cash price of the drug.

(3) Except as required by law, interfere with, prevent, or materially discourage access, exchange, or use of the information provided pursuant to subdivision (a). "Interfere with, prevent, or materially discourage access, exchange, or use of the information" includes charging fees for access to the information, not responding to a request at the time made consistent with this section, or instituting insured consent requirements.

(4) Penalize a prescribing provider for disclosing the information provided pursuant to subdivision (a). For purposes of this paragraph, “penalize” includes an action intended to punish a provider for disclosing the information set forth in subdivision (a) or intended to discourage a provider from disclosing this information in the future.

(5) Penalize a prescribing provider for prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug. For purposes of this paragraph, “penalize” includes an action intended to punish a provider who has prescribed, administered, or ordered a lower cost or clinically appropriate alternative drug, or intended to discourage a provider from prescribing, administering, or ordering a lower cost or clinically appropriate alternative drug in the future.

(c) For purposes of this section:

(1) “Cost sharing” includes applicable copayments, coinsurances, or deductibles.

(2) “Cost-sharing information” means the actual out-of-pocket amount an insured would be required to pay a dispensing pharmacy or prescribing provider for a prescription drug under the terms of the insured’s health insurance policy.

(3) “Formulary” has the same meaning as in Section 10123.192.

(4) “Interoperability element” means integrated technologies or services necessary to provide a response to an insured or an insured’s prescribing provider.

(5) “Prescribing provider” is a health care provider authorized to write a prescription to treat a medical condition, including prescriptions to treat mental health and substance use disorders, for an insured.

(6) “Standard API” means an application interface that is standardized for vendors to conform to in order to access the information pursuant to Section 170.215 of Title 45 of the Code of Federal Regulations.

(d) (1) This section does not authorize further disclosure inconsistent with the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) (Public Law 104-191) and the Confidentiality of Medical Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code).

(2) This section does not alter or interfere with requirements that a health insurer cover prescription drugs consistent with this chapter and regulations promulgated thereunder.

(3) This section does not alter or interfere with a health insurer’s other obligations under this article, including requirements to disclose or explain its prescription drug benefit.

(Added by Stats. 2022, Ch. 590, Sec. 2. (AB 2352) Effective January 1, 2023.)

10123.205. (a) (1) A health insurer that reports rate information pursuant to Section 10181.3 or 10181.45 shall report the information described in paragraph (2) to the department no later than October 1 of each year, beginning October 1, 2018.

(2) For all covered prescription drugs, including generic drugs, brand name drugs, and specialty drugs dispensed at a plan pharmacy, network pharmacy, or mail order pharmacy for outpatient use, all of the following shall be reported:

(A) The 25 most frequently prescribed drugs.

(B) The 25 most costly drugs by total annual plan spending.

(C) The 25 drugs with the highest year-over-year increase in total annual plan spending.

(b) The department shall compile the information reported pursuant to subdivision (a) into a report for the public and legislators that demonstrates the overall impact of drug costs on health care premiums. The data in the report shall be aggregated and shall not reveal information specific to individual health insurers.

(c) For the purposes of this section, a “specialty drug” is one that exceeds the threshold for a specialty drug under the Medicare Part D program (Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173)).

(d) By January 1 of each year, beginning January 1, 2018, the department shall publish on its Internet Web site the report required pursuant to subdivision (b).

(e) After the report required in subdivision (b) is released, the department shall include the report as part of the public meeting required pursuant to subdivision (b) of Section 10181.45.

(f) Except for the report required pursuant to subdivision (b), the department shall keep confidential all of the information provided to the department pursuant to this section, and the information shall be protected from public disclosure.

(Added by Stats. 2017, Ch. 603, Sec. 5. (SB 17) Effective January 1, 2018.)

10123.206. (a) Notwithstanding any other law, an individual or group health insurance policy issued, amended, or renewed on or after January 1, 2015, that provides coverage for prescribed, orally administered anticancer medications used to kill or slow the growth of cancerous cells shall comply with all of the following:

(1) Notwithstanding any deductible, the total amount of copayments and coinsurance an insured is required to pay shall not exceed two hundred fifty dollars ($250) for an individual prescription of up to a 30-day supply of a prescribed orally administered anticancer medication covered by the policy.

(2) For a health insurance policy that meets the definition of a “high deductible health plan” set forth in Section 223(c)(2) of Title 26 of the United States Code, paragraph (1) shall only apply once an insured’s deductible has been satisfied for the year.

(3) An orally administered anticancer medication shall be provided consistent with the appropriate standard of care for that medication.

(b) This section shall not apply to a specialized health insurance policy that covers only dental or vision benefits or any coverage under a health insurance policy for the Medicare Program pursuant to Title XVIII of the federal Social Security Act (42 U.S.C. Sec. 1395 et seq.).

(Amended by Stats. 2023, Ch. 607, Sec. 2. (SB 421) Effective January 1, 2024.)

10123.207. (a) Every health insurance policy, except a specialized health insurance policy, that is issued, amended, or renewed on or after January 1, 2022, shall provide coverage without cost sharing for a colorectal cancer screening test assigned either a grade of A or a grade of B by the United States Preventive Services Task Force. The required colonoscopy for a positive result on a test or procedure, other than a colonoscopy, that is a colorectal cancer screening examination or laboratory test identified assigned either a grade of A or a grade of B by the United States Preventive Services Task Force shall also be provided without any cost sharing.

(b) This section does not preclude a health insurer that has a network of providers from imposing cost-sharing requirements for the items or services described in this section that are delivered by an out-of-network provider.

(Added by Stats. 2021, Ch. 436, Sec. 2. (AB 342) Effective January 1, 2022.)

10123.208. (a) A health insurance policy issued, amended, renewed, or delivered on or after January 1, 2022, excluding specialized health insurance policies, shall provide coverage for home test kits for sexually transmitted diseases (STD), including any laboratory costs of processing the kit, that are deemed medically necessary or appropriate and ordered directly by an in-network clinician, or furnished through a standing order for patient use based on clinical guidelines and individual patient health needs.

(b) For purposes of this section, “home test kit” means a product used for a test recommended by the federal Centers for Disease Control and Prevention guidelines or the United States Preventive Services Task Force that has been CLIA-waived, FDA-cleared or -approved, or developed by a laboratory in accordance with established regulations and quality standards, to allow individuals to self-collect specimens for STDs, including HIV, remotely at a location outside of a clinical setting.

(Added by Stats. 2021, Ch. 486, Sec. 7. (SB 306) Effective January 1, 2022.)

10123.209. (a) A health insurance policy that is issued, amended, delivered, or renewed on or after July 1, 2024, shall include coverage for medically necessary biomarker testing, subject to utilization review management, pursuant to this section. Biomarker testing shall be covered for the purposes of diagnosis, treatment, appropriate management, or ongoing monitoring of an insured’s disease or condition to guide treatment decisions. Coverage shall include biomarker tests that meet any of the following:

(1) A labeled indication for a test that has been approved or cleared by the United States Food and Drug Administration (FDA) or is an indicated test for an FDA-approved drug.

(2) A national coverage determination made by the federal Centers for Medicare and Medicaid Services.

(3) A local coverage determination made by a Medicare Administrative Contractor for California.

(4) Evidence-based clinical practice guidelines, supported by peer-reviewed literature and peer-reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff.

(5) Standards set by the National Academy of Medicine.

(b) A health insurer shall use the process described in subdivision (f) of Section 10123.135 to determine whether biomarker testing is medically necessary for purposes of this section.

(c) A health insurance policy that is subject to this section shall ensure that biomarker testing is provided in a manner that limits disruptions in care, including the need for multiple biopsies or biospecimen samples. This section shall not be construed to require coverage of biomarker testing for screening purposes unless otherwise required by this part.

(d) Restricted or denied use of biomarker testing for the purpose of diagnosis, treatment, or ongoing monitoring of any medical condition is subject to grievance and appeal processes under state and federal law, including Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any regulations subsequently adopted thereunder, and the Independent Medical Review System under Article 3.5 (commencing with Section 10169).

(e) For purposes of this section, the following definitions apply:

(1) “Biomarker” means a characteristic that is objectively measured and evaluated as an indicator of normal biological processes, pathogenic processes, or pharmacological responses to a specific therapeutic intervention. A biomarker includes, but is not limited to, gene mutations or protein expression.

(2) “Biomarker testing” means the analysis of an individual’s tissue, blood, or other biospecimen for the presence of a biomarker. Biomarker testing includes, but is not limited to, single-analyte tests, multiplex panel tests, and whole genome sequencing.

(f) This section is subject to the provisions of Section 10123.20 as amended by Chapter 605 of the Statutes of 2021 for an insured with advanced or metastatic stage III or IV cancer.

(Added by Stats. 2023, Ch. 401, Sec. 2. (SB 496) Effective January 1, 2024.)

10123.210. (a) A health insurer that provides health coverage to the employees of a religious employer that does not include coverage and benefits for both abortion and contraception shall provide, in writing upon initial enrollment and annually thereafter upon renewal, each insured with information regarding both of the following:

(1) Abortion and contraception benefits or services that are not included in the insured’s health insurance policy.

(2) Abortion and contraception benefits or services that may be available at no cost through the California Reproductive Health Equity Program.

(b) For purposes of this section:

(1) “Abortion” has the same meaning as defined in Section 123464 of the Health and Safety Code.

(2) “California Reproductive Health Equity Program” means the program established pursuant to Section 127632 of the Health and Safety Code.

(3) “Contraception” means the services and contraceptive methods described in paragraph (1) of subdivision (b) of Section 10123.196.

(4) “Religious employer” has the same meaning as described in Section 10123.196.

(c) This section does not alter the applicability of any other requirement of this chapter.

(Added by Stats. 2022, Ch. 562, Sec. 3. (AB 2134) Effective January 1, 2023.)

10123.211. (a) (1) A health insurance policy that is issued, amended, or renewed on or after July 1, 2025, excluding a specialized health insurance policy, shall provide coverage for emergency room medical care and followup health care treatment for an insured who is treated following a rape or sexual assault, as defined in Sections 261, 261.6, 263, 263.1, 286, 287, and 288.7 of the Penal Code, without imposing cost sharing, including copayments, coinsurance, or deductibles, for the first nine months after the enrollee initiates treatment.

(2) For the purposes of this section, “followup health care treatment” includes medical or surgical services for the diagnosis, prevention, or treatment of medical conditions arising from an instance of rape or sexual assault.

(3) The waiver of the imposition of cost sharing pursuant to paragraph (1) shall only apply if the enrollee’s treating provider submits all requests for claims payments using accurate diagnosis codes specific to rape or sexual assault.

(b) A health insurer shall not require any of the following to provide coverage under this section:

(1) An insured to file a police report on the rape or sexual assault.

(2) Charges to be brought against an assailant.

(3) An assailant to be convicted of an offense listed in subdivision (a).

(c) (1) This section does not authorize an insured to receive followup health care treatment required to be covered by this section if treatment is furnished by a nonparticipating provider, except as specified in paragraphs (2) and (3).

(2) A health insurer shall arrange for the provision of followup health care treatment required by this section from providers outside the insurer's network if those services are unavailable within the network to ensure timely access to covered health care services consistent with Section 10133.54.

(3) A health insurer shall cover followup health care treatment if those services are for emergency services and care as defined in Section 1317.1 of the Health and Safety Code.

(d) For a health insurance policy that meets the definition of a "high deductible health plan" set forth in Section 223(c)(2) of Title 26 of the United States Code, this section shall only apply once an enrollee's deductible has been satisfied for the year.

(e) "Cost sharing" includes any copayment, coinsurance, or deductible, or any other form of cost sharing paid by the insured other than premium or share of premium.

(f) This section does not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRI-CARE supplement insurance, or to hospital indemnity, accident-only, or specified disease insurance.

(g) Coverage provided under this section is coverage of sensitive services provided to a protected individual as those terms are defined in Section 791.02 and pursuant to Section 791.29.

(Added by Stats. 2024, Ch. 971, Sec. 3. (AB 2843) Effective January 1, 2025.)

10123.21. On or after July 1, 1995, every individual or group policy of disability insurance that provides hospital, medical, or surgical coverage entered into, amended, or renewed in this state shall, subject to other terms and conditions as may be agreed upon between the group or individual policyholder and the insurer, provide coverage for the surgical procedure for those covered conditions directly affecting the upper or lower jawbone, or associated bone joints, if each procedure being considered for reimbursement is deemed medically-necessary by the insurer pursuant to the policy's definition of medical necessity. Nothing in this section shall be construed to require the provision of dental services if dental services are specifically excluded from coverage under the terms and conditions of the contract between the group or individual policyholder and insurer.

(Added by Stats. 1994, Ch. 1282, Sec. 2. Effective January 1, 1995.)

10123.22. (a) A health insurer shall not deny coverage that is otherwise available under the health insurance policy for the costs of solid organ or other tissue transplantation services based upon the insured or policyholder being infected with the human immunodeficiency virus.

(b) Notwithstanding any other provision of law, in the provision of benefits required by this section, a health insurer may utilize case management, managed care, or utilization review, subject to the terms and conditions of the policy and consistent with sound clinical processes and guidelines.

(Added by renumbering Section 10123.21 (as added by Stats. 2005, Ch. 419, Sec. 2) by Stats. 2015, Ch. 303, Sec. 370. (AB 731) Effective January 1, 2016.)

10124. (a) A self-insured employee welfare benefit plan delivered or issued for delivery in this state more than 120 days after the effective date of this section, which provides that coverage of a dependent child of an employee shall terminate upon attainment of the limiting age for dependent children specified in the policy or contract, shall also provide in substance that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to be both (1) incapable of self-sustaining employment by reason of an intellectual disability or physical handicap and (2) chiefly dependent upon the employee for support and maintenance, provided proof of the incapacity and dependency is furnished to the employer or employee organization providing the plan or program of benefits by the employee within 31 days of the child's attainment of the limiting age and subsequently as may be required by the employer or employee organization, but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

(b) As used in this section, "self-insured employee welfare benefit plan" means a plan or program of benefits provided by an employer or an employee organization, or both, for the purpose of providing hospital, medical, surgical, nursing, or dental services, or indemnification for the costs incurred for these services, to the employer's employees or their dependents.

(Amended by Stats. 2013, Ch. 76, Sec. 138. (AB 383) Effective January 1, 2014.)

10124.7. Each self-insured employee benefit plan issued or renewed on or after the effective date of this section shall provide, where feasible, that benefits for confinement in an extended care facility, as defined in subsection (j) of Section 1395x of Title 42 of the United States Code, may be provided under such terms and conditions as may be agreed upon between the employer and the employee or employee organization.

Nothing in this section shall preclude a self-insured employee benefit plan from providing benefits for confinement in institutions other than extended care facilities as defined in this section.

(Added by renumbering Section 10124 (as added by Stats. 1972, Ch. 522) by Stats. 1977, Ch. 579.)

10125. (a) On and after January 1, 1974, every insurer issuing group disability insurance which covers hospital, medical, or surgical expenses shall offer coverage for expenses incurred as a result of mental or nervous disorders, under the terms and conditions which may be agreed upon between the group policyholder and the insurer. If the terms and conditions include coverage for inpatient care for nervous or mental disorders, the coverage shall extend to treatment provided at all of the following facilities:

(1) A general acute care hospital as defined in subdivision (a) of Section 1250 of the Health and Safety Code.

(2) An acute psychiatric hospital as defined in subdivision (b) of Section 1250 of the Health and Safety Code.

(3) A psychiatric health facility as defined by Section 1250.2 of the Health and Safety Code operating pursuant to licensure by the State Department of Health Care Services.

Nothing in this subdivision prohibits an insurer that negotiates and enters into a contract with a professional or institutional provider for alternative rates of payment pursuant to Section 10133 from restricting or modifying the choice of providers.

(b) Every insurer shall communicate to prospective group policyholders as to the availability of outpatient coverage for the treatment of mental or nervous disorders. Every insurer shall communicate the availability of that coverage to all group policyholders and to all prospective group policyholders with whom they are negotiating. This coverage may include community residential treatment services, as described in former Section 5458 of the Welfare and Institutions Code, that are alternatives to institutional care.

(Amended by Stats. 2013, Ch. 23, Sec. 21. (AB 82) Effective June 27, 2013.)

10125.1. (a) Every insurer issuing disability insurance that covers hospital, medical, or surgical expenses that offers coverage for a service that is within the scope of practice of a duly licensed pharmacist shall pay or reimburse the cost of the service performed by a pharmacist at an in-network pharmacy or a pharmacist at an out-of-network pharmacy if the insurer has an out-of-network pharmacy benefit.

(b) Payment or reimbursement may be made pursuant to this section for a service performed by a duly licensed pharmacist only when all of the following conditions are met:

(1) The service performed is within the lawful scope of practice of the pharmacist.

(2) The coverage otherwise provides reimbursement for identical services performed by other licensed health care providers.

(c) Nothing in this section shall require the insurer to pay a claim to more than one provider for duplicate service or be interpreted to limit physician reimbursement.

(Amended by Stats. 2023, Ch. 322, Sec. 2. (AB 317) Effective January 1, 2024.)

10125.2. (a) A pharmacy benefit manager that contracts with a health insurer shall comply with Article 6.1 (commencing with Section 1385.001) of Chapter 2.2 of Division 2 of the Health and Safety Code, including Sections 1385.004 and 1385.006 of the Health and Safety Code.

(b) A complaint made by an insured that includes potential violations by a pharmacy benefit manager of the terms of Article 6.1 (commencing with Section 1385.001) of Chapter 2.2 of Division 2 of the Health and Safety Code shall be considered by the department to be a complaint against the health insurer.

(Added by Stats. 2025, Ch. 21, Sec. 47. (AB 116) Effective June 30, 2025.)

10126. Every policy of group disability insurance issued, amended, or renewed on or after January 1, 1977, which provides hospital, medical, or surgical expense benefits for employees or members and their dependents and which contains provisions granting the employee or member the right to convert the insurance coverage in the event of termination of employment or membership, shall include in such conversion provisions the same conversion rights and conditions to a covered dependent spouse of the employee or member in the event the covered dependent spouse ceases to be a qualified family member by reason of termination of marriage or death of the employee or member. Such conversion rights shall not require a physical examination or a statement of health.

(Amended by Stats. 1976, Ch. 1173.)

10126.5. If a disability insurance policy between an insurer that covers hospital, medical, or surgical expenses and a provider requires that the provider accept, as payment from the insurer, the lowest payment rate charged by the provider to any patient or third party, this policy provision shall not be deemed to apply to, or take into consideration, any cash payments made to the provider

by individual patients who do not have any private or public form of health care coverage for the service rendered by the provider, as described in subdivision (c) of Section 657 of the Business and Professions Code. This section shall apply to a provider contract that is issued, amended, or renewed on or after the effective date of this section.

(Added by Stats. 1998, Ch. 20, Sec. 3. Effective April 14, 1998.)

10126.6. (a) Every policy of disability insurance that provides hospital, medical, or surgical coverage under a health benefit plan, defined in subdivision (a) of Section 10198.6, that provides coverage for emergency health care services, that is issued, amended, delivered, or renewed in this state on or after January 1, 1999, shall include coverage for emergency medical transportation services, as defined in subdivision (b). This coverage shall be provided without regard to whether the emergency provider has a contractual arrangement with the insurer or whether there was prior authorization, subject to the terms and conditions of the policy.

(b) For purposes of this section, "emergency medical transportation services" means ambulance services provided through the "911" emergency response system.

(Added by Stats. 1998, Ch. 979, Sec. 5. Effective January 1, 1999.)

10126.61. (a) A health insurance policy issued, amended, or renewed on or after July 1, 2025, shall establish a process to reimburse for services provided by a community paramedicine program, triage to alternate destination program, or mobile integrated health program.

(b) (1) A health insurance policy issued, amended, or renewed on or after July 1, 2025, shall require an insured who receives covered services from a noncontracting community paramedicine program, triage to alternate destination program, or mobile integrated health program to pay no more than the same cost-sharing amount that the insured would pay for the same covered services received from a contracting community paramedicine program, triage to alternate destination program, or mobile integrated health program.

(2) Notwithstanding any other law, reimbursement rates adopted pursuant to this subdivision shall not exceed the health insurer's usual and customary charges for services rendered.

(c) For purposes of this section, the following definitions apply:

(1) "Community paramedicine program" means a program defined in Section 1815 of the Health and Safety Code.

(2) "Mobile integrated health program" means a team of licensed health care practitioners, operating within their scope of practice, who provide mobile health services to support the emergency medical services system.

(3) "Triage to alternate destination program" means a program defined in Section 1819 of the Health and Safety Code.

(Added by Stats. 2024, Ch. 884, Sec. 2. (SB 1180) Effective January 1, 2025.)

10126.65. (a) (1) Notwithstanding Section 10352, a health insurance policy issued, amended, or renewed on or after January 1, 2020, shall provide that if an insured or subscriber receives covered services from a noncontracting air ambulance provider, the insured or subscriber shall pay no more than the same cost sharing that the insured or subscriber would pay for the same covered services received from a contracting air ambulance provider. This amount shall be referred to as the "in-network cost-sharing amount."

(2) A subscriber or insured shall not owe the noncontracting provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the insurer to the noncontracting provider, the insurer shall inform the insured or subscriber and the noncontracting provider of the in-network cost-sharing amount owed by the insured or subscriber.

(b) The following shall apply for purposes of this section:

(1) Any cost sharing paid by the insured or subscriber for the services subject to this section shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.

(2) Cost sharing arising from services subject to this section shall be counted toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.

(3) The cost sharing paid by the insured or subscriber pursuant to this section shall satisfy the insured's or subscriber's obligation to pay cost sharing for the health service.

(c) A noncontracting provider may advance to collections only the in-network cost-sharing amount, as determined by the insurer pursuant to subdivision (a), that the insured or subscriber failed to pay.

(d) A health insurer or a provider may seek relief in any court for the purpose of resolving a payment dispute. A provider is not prohibited from using a health insurer's existing dispute resolution processes.

(Added by Stats. 2019, Ch. 537, Sec. 3. (AB 651) Effective January 1, 2020.)

10126.66. (a) (1) Unless otherwise required by this chapter, a health insurance policy issued, amended, or renewed on or after January 1, 2024, shall require an insured who receives covered services from a noncontracting ground ambulance provider to pay no more than the same cost-sharing amount that the insured would pay for the same covered services received from a contracting ground ambulance provider. This amount shall be referred to as the "in-network cost-sharing amount."

(2) An insured shall not owe the noncontracting ground ambulance provider more than the in-network cost-sharing amount for services subject to this section. At the time of payment by the insurer to the noncontracting provider, the insurer shall inform the insured and the noncontracting provider of the in-network cost-sharing amount owed by the insured and shall disclose whether or not the insured's coverage is regulated by the department or if the coverage is not state-regulated.

(b) (1) The in-network cost-sharing amount paid by the insured pursuant to this section shall count toward the limit on annual out-of-pocket expenses established under Section 10112.28.

(2) Cost sharing arising pursuant to this section shall count toward any deductible in the same manner as cost sharing would be attributed to a contracting provider.

(3) The in-network cost-sharing amount paid by the insured pursuant to this section shall satisfy the insured's obligation to pay cost sharing for the health service.

(c) A noncontracting ground ambulance provider shall only advance to collections the in-network cost-sharing amount, as determined by the insurer pursuant to subdivision (a), that the insured failed to pay.

(1) A noncontracting ground ambulance provider, or an entity acting on its behalf, including a debt buyer or assignee of the debt, shall not do either of the following:

(A) Report adverse information to a consumer credit reporting agency.

(B) Commence civil action against the insured for a minimum of 12 months after the initial billing regarding amounts owed by the insured pursuant to subdivision (a).

(2) With respect to an insured, a noncontracting ground ambulance provider, or an entity acting on its behalf, including an assignee of the debt, shall not use wage garnishments or liens on primary residences as a means of collecting unpaid bills pursuant to this section.

(d) (1) Unless otherwise agreed to by the noncontracting ground ambulance provider and the health insurer, the insurer shall directly reimburse a noncontracting ground ambulance provider for ground ambulance services the difference between the in-network cost-sharing amount and an amount described, as follows:

(A) If there is a rate established or approved by a local government, at the rate established or approved by the governing body of the local government having jurisdiction for that area or subarea, including an exclusive operating area pursuant to Section 1797.85 of the Health and Safety Code.

(B) If the local government having jurisdiction where the service was provided does not have an established or approved rate for that service, the reasonable and customary value for the services rendered, based upon statistically credible information that is updated at least annually and takes into consideration all of the following:

(i) The ambulance provider's training, qualifications, and length of time in practice.

(ii) The nature of the services provided.

(iii) The fees usually charged by the ambulance provider.

(iv) Prevailing ground ambulance provider rates charged in the general geographic areas in which the services were rendered.

(v) Other aspects of the economics of the ambulance provider's practice that are relevant.

(vi) Any unusual circumstances in the case.

(2) A local government has jurisdiction over the ground ambulance transport if either of the following applies:

(A) The ground ambulance transport is initiated within the boundaries of the local government's regulatory jurisdiction.

(B) In the case of ground ambulance transports provided on a mutual or automatic aid basis into another jurisdiction, the local government where the noncontracting ground ambulance provider is based.

(3) A payment made by the health insurer to the noncontracting ground ambulance provider for services as required in subdivision (a), plus the applicable cost sharing owed by the insured, shall constitute payment in full for services rendered.

(4) Notwithstanding any other law, the amounts paid by a health insurer for services under this section shall not constitute the prevailing or customary charges, the usual fees to the general public, or other charges for other payers for an individual ground ambulance provider.

(e) A health insurer or ground ambulance provider may seek relief in any appropriate court for the purpose of resolving a payment dispute. A ground ambulance provider may use a health insurer's existing dispute resolution process under Section 10123.137.

(f) This section does not affect the balance billing protections for Medi-Cal beneficiaries under Section 14019.4 of the Welfare and Institutions Code.

(Amended by Stats. 2024, Ch. 520, Sec. 13. (SB 1061) Effective January 1, 2025.)

10127. On and after January 1, 1974, every self-insured employee welfare benefit plan that provides coverage for hospital, medical, or surgical expenses shall offer coverage for expenses incurred as a result of mental or nervous disorders, under the terms and conditions which may be agreed upon between the self-insured welfare benefit plan and the member. If the terms and conditions include coverage for services provided in a general acute care hospital, or an acute psychiatric hospital as defined in Section 1250 of the Health and Safety Code, and do not restrict or modify the choice of providers, the coverage shall extend to care provided by a psychiatric health facility, as defined by Section 1250.2 of the Health and Safety Code, operating pursuant to licensure by the State Department of Health Care Services. Every plan shall communicate to prospective members as to the availability of outpatient coverage for the treatment of mental or nervous disorders. Every self-insured welfare benefit plan shall communicate the availability of this coverage to all members and prospective members. This coverage may include community residential treatment services, as described in former Section 5458 of the Welfare and Institutions Code, that are alternatives to institutional care.

(Amended by Stats. 2013, Ch. 23, Sec. 22. (AB 82) Effective June 27, 2013.)

10127.09. Notwithstanding any other law, a disability insurance policy that provides hospital, medical, surgical, prescription drug, or nursing benefits, except a policy providing only dental or vision benefits, that is issued, amended, renewed, or delivered, on or after January 1, 2024, and that is issued to a bona fide public or private institution of higher learning and provides coverage to its students and their dependents, or to its faculty, staff, administration, and their respective dependents, shall comply with the coverage requirements of Sections 10123.1945 and 10123.196.

(Added by Stats. 2022, Ch. 630, Sec. 18. (SB 523) Effective January 1, 2023.)

10127.1. (a) No policy of disability insurance providing loss of time benefits shall contain any provision for a reduction of such benefits during a benefit period because of an increase in benefits payable under the Federal Social Security Act, as amended.

(b) No self-insured employee welfare benefit plan providing loss of time benefits shall contain any provision for a reduction of such benefits during a benefit period because of an increase in benefits payable under the Federal Social Security Act, as amended.

(c) This section shall apply to all disability insurance policies issued, delivered, amended, or renewed in this state on or after January 1, 1977, and shall apply to group disability insurance policies and self-insured employee welfare benefit plans which are entered into, amended, or renewed on or after such date or upon the expiration of any applicable collective-bargaining agreement, whichever occurs later.

(Added by Stats. 1976, Ch. 68.)

10127.15. Any provision contained in a policy of disability insurance or a self-insured employee welfare benefit plan for a reduction of loss of time benefits during a benefit period because of an increase in benefits payable under the federal Social Security Act, as amended, shall be null and void with respect to any such increase which occurs on or after the effective date of this section.

(Added by Stats. 1977, Ch. 272.)

10127.2. Each policy of disability insurance issued or renewed on or after the effective date of this section, which policy provides benefits that accrue after a certain time of confinement in a health care facility, shall specify what constitutes a day of confinement or the number of consecutive hours of confinement which are requisite to the commencement of benefits.

With respect to renewal of individual policies of disability insurance, insurers shall not be required to issue notification to the insured of the provisions of this section unless notice of policy renewal is delivered to the insured.

(Added by Stats. 1978, Ch. 648.)

10127.21. Any data submitted by a health insurer to the United States Secretary of Health and Human Services, or his or her designee, for purposes of the risk adjustment program described in Section 1343 of the federal Patient Protection and Affordable Care Act (42 U.S.C. Sec. 18063) shall be concurrently submitted to the department and in the same format. The department shall use the information to monitor federal implementation of risk adjustment in the state and to ensure that insurers are in compliance with federal requirements related to risk adjustment.

(Added by Stats. 2013, 1st Ex. Sess., Ch. 1, Sec. 6. (AB 2 1x) Effective September 30, 2013.)

10127.3. On and after January 1, 1985, every insurer issuing group disability insurance which covers hospital, medical, or surgical expenses shall offer coverage for expenses incurred as a result of treatment by holders of certificates under Section 4938 of the Business and Professions Code, under such terms and conditions as may be agreed upon between the group policyholder and the insurer.

An insurer is not required to offer the coverage provided by this section as part of any policy covering employees of a public entity.

(Added by Stats. 1984, Ch. 1067, Sec. 2.)

10127.4. (a) Except as provided in subdivisions (b) and (c), no contract that is issued, amended, renewed, or delivered on or after January 1, 1999, between a disability insurer that provides coverage for hospital, medical, or surgical benefits and a health care provider shall contain provisions that prohibit, restrict, or limit the health care provider from advertising.

(b) Nothing in this section shall be construed to prohibit disability insurers from establishing reasonable guidelines in connection with the activities regulated pursuant to this part, including those to prevent advertising that is, in whole or in part, untrue, misleading, deceptive, or otherwise inconsistent with this part or the rules and regulations promulgated thereunder. For advertisements mentioning a provider's participation in a plan or product line of a disability insurer, nothing in this section shall be construed to prohibit disability insurers from requiring each advertisement to contain a disclaimer to the effect that the provider's services may be covered for some, but not all, plans or product lines of the disability insurer, or that the disability insurer may cover some, but not all, provider services.

(c) Nothing in this section is intended to prohibit provisions or agreements intended to protect service marks, trademarks, trade secrets, or other confidential information or property. If a health care provider participates in a provider panel or network as a result of a direct contractual agreement with a disability insurer that, in turn, has entered into a direct contractual agreement with another person or entity, pursuant to which insureds and other beneficiaries of that other person or entity may receive covered services from the health care provider, then nothing in this section is intended to prohibit reasonable provisions or agreements in the direct contractual arrangement between the health care provider and the disability insurer that protect the name or trade name of the other person or entity or requires that the health care provider obtain the consent of the disability insurer prior to the use of the name or trade name of the other person or entity in any advertising by the health care provider.

(d) Nothing in this section shall be construed to impair or impede the authority of the commissioner to regulate advertising, disclosure, or solicitation pursuant to this part.

(Added by Stats. 1998, Ch. 523, Sec. 4. Effective January 1, 1999.)

10127.5. Every application for, certificate of, and policy of credit life or credit disability insurance shall set forth a statement in bold capital letters indicating that any preexisting health condition of the applicant may render the coverage void, if that is the case.

For the purpose of this section, "credit life or credit disability insurance" means insurance on the life or health of any borrower sold by any creditor to provide for the repayment of the amount of a loan or other extension of credit in the event of the debtor's death or disability as defined in the policy.

(Amended by Stats. 1984, Ch. 1200, Sec. 6. Effective September 17, 1984.)

10127.7. Every policy of individual life insurance with a face value of less than ten thousand dollars ($10,000) which is delivered or issued for delivery in this state on and after July 1, 1974, shall have printed thereon or attached thereto a notice stating that, after receipt of the policy by the owner, the policy may be returned by the owner for cancellation by delivering it or mailing it to the insurer or to the agent through whom it was purchased. The period of time set forth by the insurer for return of the policy by the insured shall be clearly stated on the notice and this period shall be not less than 10 days nor more than 30 days. The insured may return the policy to the insurer at any time during the period specified in the notice. This delivery or mailing of the policy by the owner shall void the policy from the beginning, and the parties shall be in the same position as if no policy or contract had been issued. All premiums paid and any policy fee paid for the policy shall be refunded to the owner within 30 days from the date that the insurer is notified that the insured has canceled the policy.

This section applies to all policies issued, amended, or delivered in this state on or after January 1, 2011, and applies to any renewal thereof. All policies subject to this section that are in effect on January 1, 2011, shall be construed to be in compliance with this section, and any provision in such a policy that is in conflict with this section shall be of no force or effect.

This section does not apply to individual life insurance policies issued in connection with a credit transaction or issued under a contractual policy change or conversion privilege provision contained in a policy.

(Amended by Stats. 2010, Ch. 184, Sec. 1. (SB 1405) Effective January 1, 2011.)

10127.8. (a) The purpose of this section is to assure truthful and adequate disclosure of all material and relevant information in the advertising of term life insurance which the commissioner, on the basis of an assessment of the total advertisement, determines is directed to individuals 55 years of age or older.

(b) Advertisements for term life insurance directed to individuals 55 years of age or older shall:

(1) Clearly and prominently distinguish basic life insurance benefits from suppplemental benefits such as accidental death benefits.

(2) Prominently disclose any limitations, exceptions, or reductions affecting each benefit.

(3) Prominently disclose any condition affecting the policy or certificate holder's continued insurability. If term coverage terminates at a stated age, or at the end of any designated period, that fact and the specified age or designated period shall be disclosed.

(4) Prominently disclose any change in benefits resulting from the aging of the insured, policy duration, or any other factor.

(5) Prominently disclose any change in premium resulting from the aging of the insured, policy duration, or any other factor. If the insurer retains any right to modify premiums in the future, that fact shall be disclosed.

(c) If the benefits of the advertised policy or certificate decrease with the insured's age or with policy or certificate duration, while the premium remains approximately constant, that fact shall, in a print or broadcast advertisement, be disclosed, in the same form and with prominence or visible duration, or both, equal to that given any positive description of benefits or the telephone number or address provided for further information or application, whichever is the most prominent.

(d) A television or radio advertisement for term life insurance directed to individuals 55 years of age or older shall in the spoken text contain the statement "policy (or certificate) benefits and limitations should be carefully examined prior to purchase."

(e) The commissioner may, by regulation, adopt a term life insurance monetary value index, similar to the Life Insurance Surrender Cost Index of Article 12.5 (commencing with Section 2545) of Subchapter 2 of Chapter 5 of Title 10 of the California Code of Regulations, to be disclosed in all advertisements of term life insurance for individuals 55 years of age or older, and on all policies and certificates of that insurance. In developing a term life insurance monetary value index, the commissioner shall consider actual premiums and policy and certificate benefits and the manner in which they are affected with the passage of time. Any term life insurance monetary value index developed pursuant to this section shall assume an insured's desire to retain coverage for at least 10 years.

(f) This section does not supersede or repeal any regulation of the commissioner which governs life insurance advertising and such regulation shall continue to be in force in addition to this section.

(g) The commissioner shall adopt regulations that are necessary to carry out this section.

(h) This section applies to the advertisement of individual policies of insurance and any group policies or certificates delivered or issued for delivery in this state, regardless of the situs of the contract.

(i) In addition to any other penalty provided by law or the availability of any administrative procedure, if an insurer, after notice and hearing, is found to have violated this section, or regulations adopted pursuant to this section, or knowingly permits any person to do so, the commissioner, in accordance with the procedures provided in Section 704, may suspend the insurer's certificate of authority to transact life insurance. Section 704.7 shall apply in any proceeding conducted pursuant to this section.

(Added by Stats. 1988, Ch. 1473, Sec. 1.)

10127.9. (a) (1) Every individual life insurance policy and every individual annuity contract that is initially delivered or issued for delivery in this state on and after January 1, 1990, shall have printed on the front of the policy jacket or on the cover page a notice stating that, after receipt of the policy by the owner, the policy may be returned by the owner for cancellation by mail or other delivery method to the insurer or to the agent through whom it was purchased. The period of time set forth by the insurer for return of the policy by the owner shall be clearly stated and this period shall be not less than 10 days nor more than 30 days.

(2) The owner may return the policy to the insurer by mail or other delivery method at any time during the period specified in the notice. In the case of individual nonvariable life insurance policies and individual nonvariable annuity contracts, including modified

guaranteed contracts, by delivering or mailing the policy pursuant to this section during the cancellation period, the owner shall void the policy from the beginning, and the parties shall be in the same position as if no policy had been issued. All premiums paid and any policy fee paid for the policy shall be refunded by the insurer to the owner within 30 days from the date that the insurer is notified that the owner has canceled the policy. In the case of individual variable annuity contracts and individual variable life insurance policies, return of the policy during the cancellation period shall entitle the owner to a refund of the account value and any policy fee paid for the policy. The account value and policy fee shall be refunded by the insurer to the owner within 30 days from the date that the insurer is notified that the owner has canceled the policy.

(b) This section applies to all individual policies issued or delivered in this state on or after January 1, 1990, but does not apply to any policy subject to Section 10127.7. All policies subject to this section which are in effect on January 1, 1990, shall be construed to be in compliance with this section, and any provision in any policy which is in conflict with this section shall be of no force or effect.

(c) This section does not apply to individual life insurance policies issued in connection with a credit transaction or issued under a contractual policy-change or conversion privilege provision contained in a policy.

(d) General references to “policy” or “policies” in this section refer to both life insurance policies and annuity contracts.

(e) This section shall become operative on July 1, 2015.

(Repealed (in Sec. 3) and added by Stats. 2014, Ch. 166, Sec. 4. (AB 2347) Effective January 1, 2015. Section operative July 1, 2015, by its own provisions.)

10127.10. (a) Every policy of individual life insurance and every individual annuity contract that is initially delivered or issued for delivery to a senior citizen in this state on and after July 1, 2004, shall have printed on the front of the policy jacket or on the cover page a notice stating that, after receipt of the policy by the owner, the policy may be returned by the owner for cancellation by mail or other delivery method to the insurer or agent from whom it was purchased. The period of time set forth by the insurer for return of the policy by the owner shall be clearly stated in the notice and this period shall be not less than 30 days. The owner may return the policy to the insurer by mail or other delivery method at any time during the period specified in the notice. During the 30-day cancellation period, the premium for an individual variable life insurance policy or an individual variable annuity contract may be invested only in fixed-income investments and money-market funds, unless the owner specifically directs that the premium be invested in the mutual funds underlying the variable life insurance policy or variable annuity contract. Return of the policy within the 30-day cancellation period shall have one of the following effects:

(1) In the case of individual variable life insurance policies and individual variable annuity contracts for which the owner has not directed that the premium be invested in the mutual funds underlying the policy during the cancellation period, return of the policy during the cancellation period shall have the effect of voiding the policy from the beginning, and the parties shall be in the same position as if no policy had been issued. All premiums paid and any policy fee paid for the policy shall be refunded by the insurer to the owner within 30 days from the date that the insurer is notified that the owner has canceled the policy.

(2) In the case of individual variable life insurance policies and individual variable annuity contracts for which the owner has directed that the premium be invested in the mutual funds underlying the policy during the 30-day cancellation period, cancellation shall entitle the owner to a refund of the account value and any policy fee paid for the policy. The account value shall be refunded by the insurer to the owner within 30 days from the date that the insurer is notified that the owner has canceled the policy.

(b) This section applies to all individual life insurance policies and all individual annuity contracts issued or delivered to senior citizens in this state on or after January 1, 2004. All policies subject to this section which are in effect on January 1, 2003, shall be construed to be in compliance with this section, and any provision in any policy which is in conflict with this section shall be of no force or effect.

(c) Every individual nonvariable life insurance policy and every individual nonvariable annuity contract, including modified guaranteed annuity contracts, subject to this section, that is delivered or issued for delivery in this state shall have the following notice printed on the front of the policy jacket or on the cover page in 12-point bold print with one inch of space on all sides, using the exact language in quotation marks below, with whichever one of the three bracketed product descriptions that applies to the product on which the notice appears:

“IMPORTANT!

You have purchased a [life insurance policy], [annuity contract], [modified guaranteed annuity contract], referred to below as a “policy.” Carefully review it for limitations.

This policy may be returned within 30 days from the date you received it for a full refund by returning it to the insurance company or agent who sold you this policy. After 30 days, cancellation may result in a substantial penalty, known as a surrender charge.”

The sentence “After 30 days, cancellation may result in a substantial penalty, known as a surrender charge” may be deleted if the policy does not contain a surrender charge. The phrase “known as a surrender charge” may be deleted if the policy contains a

penalty but no surrender charge. If the policy contains both a penalty, or penalties, and a surrender charge, the sentence shall state that cancellation may result in “substantial penalties, including a surrender charge.” Whether a charge constitutes a surrender charge or a penalty shall be determined by the nature of the charge and not the name given to the charge by the insurer. If the surrender charge is called a “withdrawal charge” in the policy, the insurer shall add the following sentence at the end of the notice:

“In this policy the surrender charge is called a ‘withdrawal charge.’”

(d) Every individual variable life insurance policy and every individual variable annuity contract subject to this section, that is delivered or issued for delivery in this state, shall have the following notice printed on the front of the policy jacket or on the cover page in 12-point bold print with one inch of space on all sides, using the exact language in quotation marks below, with whichever one of the two bracketed product descriptions that applies to the product on which the notice appears:

“IMPORTANT!

You have purchased a [variable life insurance policy], [variable annuity contract], referred to below as a “policy.” Carefully review it for limitations.

This policy may be returned within 30 days from the date you received it. During that 30-day period, your money will be placed in a fixed account or money-market fund, unless you direct that the premium be invested in a stock or bond portfolio underlying the policy during the 30-day period. If you do not direct that the premium be invested in a stock or bond portfolio, and if you return the policy within the 30-day period, you will be entitled to a refund of the premium and any policy fee paid. If you direct that the premium be invested in a stock or bond portfolio during the 30-day period, and if you return the policy during that period, you will be entitled to a refund of the policy’s account value on the day the policy is received by the insurance company or agent who sold you this policy, which could be less than the premium you paid for the policy, plus any policy fee paid. A return of the policy after 30 days may result in a substantial penalty, known as a surrender charge.”

The sentence “A return of the policy after 30 days may result in a substantial penalty, known as a surrender charge” may be deleted if the policy does not contain a surrender charge. If the policy contains both a penalty, or penalties, and a surrender charge, the sentence shall state that cancellation may result in “substantial penalties, including a surrender charge.” The phrase “known as a surrender charge” may be deleted if the policy contains a penalty but no surrender charge. Whether or not a charge constitutes a surrender charge or a penalty will be determined by the nature of the charge and not the name given to the charge by the insurer. If the surrender charge is called a “withdrawal charge” in the policy, the insurer shall add the following sentence at the end of the notice:

“In this policy the surrender charge is called a ‘withdrawal charge.’”

(e) If the individual annuity contract is an immediate annuity contract, the following sentence, using the exact language in quotation marks below, in 12-point bold print, shall be added at the end of the right to examine language required by this section and before the one inch of space:

“After the 30-day period has expired, you may not be able to get your purchase payment money back in any manner, or in any manner other than in annuity payments made according to the terms of your contract. The insurance company or agent who sold you this contract can explain if your contract has these restrictions.”

(f) This section does not apply to life insurance policies issued in connection with a credit transaction or issued under a contractual policy-change or conversion privilege provision contained in a policy.

(g) For purposes of this chapter, a senior citizen means an individual who is 60 years of age or older on the date of purchase of the policy.

(h) General references to “policy” or “policies” in this section refer to both life insurance policies and annuity contracts.

(i) This section shall become operative on July 1, 2015.

(Repealed (in Sec. 5) and added by Stats. 2014, Ch. 166, Sec. 6. (AB 2347) Effective January 1, 2015. Section operative July 1, 2015, by its own provisions.)

10127.11. Every insurer and life agent offering for sale individual life insurance policies or individual annuity contracts that are initially delivered or issued for delivery to senior citizens in this state on and after January 1, 1995, with the use of nonpreprinted illustrations of nonguaranteed values shall disclose on those illustrations or on an attached cover sheet, in bold or underlined capitalized print, or in the form of a contrasting color sticker, bright highlighter pen, or in any manner that makes it more prominent than the surrounding material, with at least one-half inch space on all four sides, the following statement:

“THIS IS AN ILLUSTRATION ONLY. AN ILLUSTRATION IS NOT INTENDED TO PREDICT ACTUAL PERFORMANCE. INTEREST RATES, DIVIDENDS, OR VALUES THAT ARE SET FORTH IN THE ILLUSTRATION ARE NOT GUARANTEED, EXCEPT FOR THOSE ITEMS CLEARLY LABELED AS GUARANTEED.”

All preprinted policy illustrations shall contain this notice in 12-point bold print with at least one-half inch space on all four sides and shall be printed on the illustration form itself or on an attached cover sheet, or in the form of a contrasting color sticker placed on the front of the illustration. All preprinted illustrations containing nonguaranteed values shall show the columns of guaranteed values in bold print. All other columns used in the illustration shall be in standard print. “Values” as used here includes cash value, surrender value, and death benefit.

(Amended by Stats. 1998, Ch. 379, Sec. 1. Effective January 1, 1999.)

10127.12. Whenever an insurer provides an annual statement to a senior citizen policyowner of an individual life insurance policy or an individual annuity contract issued after January 1, 1995, the insurer shall also provide the current accumulation value and the current cash surrender value.

(Amended by Stats. 1994, Ch. 984, Sec. 3. Effective September 29, 1994.)

10127.13. (a) All individual life insurance policies and individual annuity contracts for senior citizens that contain a charge upon surrender, partial surrender, excess withdrawal, or penalties upon surrender shall contain a notice disclosing the location of all of the following: the charge, the charge time period, the charge information, and any associated penalty information. The notice shall be in bold 12-point type on the front of the policy jacket or on the cover page of the policy.

(b) A policy shall have just one cover page. If the notice required by this section and the statutorily required right to examine notice are both on the cover page, as opposed to the front cover of the policy jacket, they shall appear on the same page.

(c) General references to “policy” in this section refer to both life insurance policies and annuity contracts.

(d) This section shall become operative on July 1, 2015.

(Amended (as added by Stats. 2014, Ch. 166, Sec. 8) by Stats. 2015, Ch. 348, Sec. 17. (AB 1515) Effective January 1, 2016.)

10127.14. (a) The department and the Department of Managed Health Care shall compile information required by this section and Section 1363.06 of the Health and Safety Code into two comparative benefit matrices. The first matrix shall compare benefit packages offered pursuant to Section 1373.62 of the Health and Safety Code and Section 10127.15. The second matrix shall compare benefit packages offered pursuant to Sections 1366.35, 1373.6, and 1399.804 of the Health and Safety Code and Sections 10785, 10901.2, and 12682.1.

(b) The comparative benefit matrix shall include:

(1) Benefit information submitted by health care service plans pursuant to Section 1363.06 of the Health and Safety Code and by health insurers pursuant to subdivision (d).

(2) The following statements in at least 12-point type at the top of the matrix:

(A) “This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact the health care service plan or health insurer.”

(B) “The comparative benefit summary is updated annually, or more often if necessary to be accurate.”

(C) “The most current version of this comparative benefit summary is available on (address of the plan’s or insurer’s site).”

This subparagraph applies only to those health insurers that maintain an Internet Web site.

(3) The telephone number or numbers that may be used by an applicant to contact either the department or the Department of Managed Health Care, as appropriate, for further assistance.

(c) The department and the Department of Managed Health Care shall jointly prepare two standardized templates for use by health care service plans and health insurers in submitting the information required pursuant to subdivision (d) of Section 1363.06 and subdivision (d). The templates shall be exempt from the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) Health insurers shall submit the following to the department by January 31, 2003, and annually thereafter:

(1) A summary explanation of the following for each product described in subdivision (a):

(A) Eligibility requirements.

(B) The full premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside.

(C) When and under what circumstances benefits cease.

(D) The terms under which coverage may be renewed.

(E) Other coverage that may be available if benefits under the described benefit package cease.

(F) The circumstances under which choice in the selection of physicians and providers is permitted.

(G) Lifetime and annual maximums.

(H) Deductibles.

(2) A summary explanation of the following coverages, together with the corresponding copayments and limitations, for each product described in subdivision (a):

(A) Professional services.

(B) Outpatient services.

(C) Hospitalization services.

(D) Emergency health coverage.

(E) Ambulance services.

(F) Prescription drug coverage.

(G) Durable medical equipment.

(H) Mental health services.

(I) Residential treatment.

(J) Chemical dependency services.

(K) Home health services.

(L) Custodial care and skilled nursing facilities.

(3) The telephone number or numbers that may be used by an applicant to access a health insurer customer service representative and to request additional information about the insurance policy.

(4) Any other information specified by the department in the template.

(e) Each health insurer shall provide the department with updates to the information required by subdivision (d) at least annually, or more often if necessary to maintain the accuracy of the information.

(f) The department and the Department of Managed Health Care shall make the comparative benefit matrices available on their respective Internet Web sites and to the health care service plans and health insurers for dissemination as required by Section 1373.6 of the Health and Safety Code and Section 12682.1, after confirming the accuracy of the description of the matrices with the health insurers and health care service plans.

(g) As used in this section, “benefit matrix” shall have the same meaning as benefit summary.

(h) This section shall not apply to accident-only, specified disease, hospital indemnity, CHAMPUS supplement, long-term care, Medicare supplement, dental-only, or vision-only insurance policies.

(i) (1) This section shall be inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300g-91), this section shall become operative on the date of that repeal or amendment.

(3) For purposes of this subdivision, “PPACA” means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

(Amended by Stats. 2013, Ch. 441, Sec. 14. (AB 1180) Effective October 1, 2013. Inoperative, by its own provisions, on January 1, 2014, subject to condition for resuming operation.)

10127.16. (a) (1) After the termination of the pilot program under Section 10127.15, a health insurer shall continue to provide coverage under the same terms and conditions specified in Section 10127.15 as it existed on January 1, 2007, including the terms of the standard benefit plan and the subscriber payment amount, to each individual who was terminated from the program, pursuant to subdivision (f) of Section 12725 of the Insurance Code during the term of the pilot program and who enrolled or applied to enroll in a standard benefit plan within 63 days of termination. The State Department of Health Care Services shall continue to pay the amount described in Section 10127.15 for each of those individuals. A health insurer shall not be required to offer the coverage described in Section 10127.15 after the termination of the pilot program to individuals not already enrolled in the program.

(2) Notwithstanding paragraph (1) of this subdivision or Section 10127.15 as it existed on January 1, 2007, the following rules shall apply:

(A) (i) A health insurer shall not be obligated to provide coverage to any individual pursuant to this section on or after January 1, 2014.

(ii) The State Department of Health Care Services shall not be obligated to provide any payment to any health insurer under this section for (I) health care expenses incurred on or after January 1, 2014, or (II) the standard monthly administrative fee, as defined in Section 10127.15 as it existed on January 1, 2007, for any month after December 2013.

(B) Each health insurer providing coverage pursuant to this section shall, on or before October 1, 2013, send a notice to each individual enrolled in a standard benefit plan that is in at least 12-point type and with, at minimum, the following information:

(i) Notice as to whether or not the plan will terminate as of January 1, 2014.

(ii) The availability of individual health coverage, including through Covered California, including at least all of the following:

(I) That, beginning on January 1, 2014, individuals seeking coverage may not be denied coverage based on health status.

(II) That the premium rates for coverage offered by a health care service plan or a health insurer cannot be based on an individual's health status.

(III) That individuals obtaining coverage through Covered California may, depending upon income, be eligible for premium subsidies and cost-sharing subsidies.

(IV) That individuals seeking coverage must obtain this coverage during an open or special enrollment period, and a description of the open and special enrollment periods that may apply.

(C) As a condition of receiving payment for a reporting period pursuant to this section, a health insurer shall provide the State Department of Health Care Services with a complete, final annual reconciliation report by the earlier of December 31, 2014, or an earlier date as prescribed by Section 10127.15, as it existed on January 1, 2007, for that reporting period. To the extent that it receives a complete, final reconciliation report for a reporting period by the date required pursuant to this subparagraph, the State Department of Health Care Services shall complete reconciliation with the health insurer for that reporting period within 18 months after receiving the report.

(b) If the state fails to expend, pursuant to this section, sufficient funds for the state's contribution amount to any health insurer, the health insurer may increase the monthly payments that its subscribers are required to pay for any standard benefit plan to the amount that the State Department of Health Care Services would charge without a state subsidy for the same insurance product issued to the same individual within the program.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the State Department of Health Care Services may implement, interpret, or make specific this section by means of all-county letters, plan letters, plan or provider bulletins, or similar instructions, without taking regulatory action.

(Amended by Stats. 2015, Ch. 18, Sec. 25. (SB 75) Effective June 24, 2015.)

10127.17. (a) The Life and Annuity Consumer Protection Fund is hereby created as a special account within the Insurance Fund. Each insurer admitted to transact insurance in this state shall pay a fee to be determined by the commissioner, not to exceed one dollar ($1), for each individual life insurance policy and each individual annuity product that it issues to a resident of this state. If an insurer elects to charge the purchaser of a life insurance policy or annuity product this fee, the fee shall be set forth as a separate charge in the contract schedule or premium notice. Life insurance or annuity forms are not required to be filed again for review as a consequence of this provision. The revenue from this fee shall be deposited into the Life and Annuity Consumer Protection Fund.

(b) Moneys in the Life and Annuity Consumer Protection Fund shall be distributed by the commissioner, upon appropriation by the Legislature, to fund the reasonable costs incurred in regulating entities transacting life insurance and annuity products in this state. Moneys in the fund shall not be used for any other purpose.

(c) Fifty percent of these funds shall be distributed within the department for functions related to individual life insurance and annuity products, including, but not limited to:

(1) Investigating and prosecuting financial abuse by insurance licensees, or persons holding themselves out to be insurance licensees, or any person purporting to be engaged in the business of insurance.

(2) Responding to consumer inquiries and complaints related to life insurance or annuity products.

(3) Disseminating information to insurers, insureds, and others regarding the applicable regulation of life insurance and annuity products, including consumer protection, purchasing and using insurance and annuity products, claim filing, benefit delivery, and dispute resolution.

(4) Regulating and overseeing life insurance and annuity products and advertising for these products directed toward consumers.

(d) Fifty percent of the funds shall be distributed to district attorneys for investigating and prosecuting individual life insurance and annuity product financial abuse cases involving insurance licensees, or persons holding themselves out to be insurance licensees, or any person purporting to be engaged in the business of insurance, and for other projects beneficial to insurance consumers.

(1) The commissioner shall distribute funds to district attorneys who are able to show a likely positive outcome that will benefit consumers in the local jurisdiction based on specific criteria promulgated by the commissioner. Each local district attorney desiring a portion of those funds shall submit to the commissioner an application, including, at a minimum all of the following:

(A) The proposed use of the moneys and the anticipated outcome.

(B) A list of all prior relevant cases or projects and a copy of the final accounting for each. If cases or projects are ongoing, the most recent accounting shall be provided.

(C) A detailed budget, including salaries and general expenses, and specifically identifying the cost of purchase or rental of equipment or supplies.

(2) Each district attorney that receives funds pursuant to this section shall submit a final detailed accounting at the conclusion or closure of each case or project. For cases or projects that continue longer than six months, interim accountings shall be submitted every six months, or as otherwise directed by the commissioner.

(3) Each district attorney that receives funds pursuant to this section shall submit a final report to the commissioner, which may be made public, as to the success of the case or project conducted. The report shall provide information and statistics on the number of active investigations, arrests, indictments, and convictions. The applications for moneys, the distribution of moneys, and the annual reports shall be public documents.

(4) Notwithstanding any other provision of this section, information submitted to the commissioner pursuant to this section concerning criminal investigations, whether active or inactive, shall be confidential.

(5) The commissioner may conduct a fiscal audit of the programs administered under this subdivision. This fiscal audit shall be conducted by an internal audit unit of the department. The cost of any fiscal audits shall be paid for from the Life and Annuity Consumer Protection Fund established by this section.

(6) If the commissioner determines that a district attorney is unable or unwilling to investigate or prosecute a relevant financial abuse case, the commissioner may discontinue distribution of funds allocated for that matter and may redistribute those funds to other eligible district attorneys.

(e) If, as of June 30 of any calendar year, the total amount in the Life and Annuity Consumer Protection Fund exceeds five million dollars ($5,000,000), the commissioner shall reduce the amount of the assessment accordingly for the following year to eliminate that excess. An insurer, upon receipt of an invoice, shall transmit payment to the department for deposit in the Life and Annuity Consumer Protection Fund. Any balance remaining in the Life and Annuity Consumer Protection Fund at the end of the fiscal year shall be retained in the account, to be available in the next fiscal year.

(f) The commissioner may develop guidelines for implementing or clarifying these provisions, including guidelines for the allocation, distribution, and potential return of unused funds. The commissioner may, from time to time, issue regulations for implementing or clarifying these provisions.

(g) The commissioner shall provide a consolidated report annually on the department’s Internet Web site, which shall include, but is not limited to, the following information:

(1) The number of opened consumer complaints related to life insurance or annuity products.

(2) The number of opened investigations related to life insurance or annuity products.

(3) The number of investigations related to life insurance or annuity products referred to and reported by prosecuting agencies.

(4) The number of administrative or regulatory cases related to life insurance or annuity products referred to the department's legal division.

(5) The number of administrative or regulatory enforcement actions taken in cases related to life insurance or annuity products.

(6) Descriptions of efforts by the department to disseminate information to insurers and others regarding the applicable regulation of life insurance and annuity products, including consumer protection, purchasing and using insurance and annuity products, claim filing, benefit delivery, and dispute resolution.

(Repealed and added by Stats. 2013, Ch. 347, Sec. 7. (SB 476) Effective January 1, 2014.)

10127.18. (a) On and after January 1, 2005, a health insurer issuing individual policies of health insurance that ceases to offer individual coverage in this state shall offer coverage to the policyholders who had been covered by those policies at the time of withdrawal under the same terms and conditions as provided in paragraph (3) of subdivision (a), paragraphs (2) to (4), inclusive, of subdivision (b), subdivisions (c) to (e), inclusive, and subdivision (h) of Section 12682.1.

(b) The department may adopt regulations to implement this section.

(c) This section shall not apply when a plan participating in Medi-Cal, Healthy Families, Access for Infants and Mothers, or any other contract between the plan and a government entity no longer contracts with the government entity to provide health coverage in the state, or a specified area of the state, nor shall this section apply when a plan ceases entirely to market, offer, and issue any and all forms of coverage in any part of this state after the effective date of this section.

(d) (1) This section shall be inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative on the date of that repeal or amendment.

(3) For purposes of this subdivision, "PPACA" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any rules, regulations, or guidance issued pursuant to that law.

(Amended by Stats. 2013, Ch. 441, Sec. 16. (AB 1180) Effective October 1, 2013. Inoperative, by its own provisions, on January 1, 2014, subject to condition for resuming operation.)

10127.19. (a) Commencing March 1, 2013, and at least annually thereafter, a health insurer, not including a health insurer offering specialized health insurance policies, shall provide to the department, in a form and manner determined by the department in consultation with the Department of Managed Health Care, the number of covered lives, by product type, as of December 31 of the prior year, that receive health care coverage under a health insurance policy that covers individuals and small groups inside and outside of the California Health Benefit Exchange, large groups, administrative services only business lines, and any other business lines. Health insurers shall include the unduplicated enrollment data in specific product types as determined by the department, including, but not limited to, HMO, point-of-service, PPO, grandfathered, and Medi-Cal managed care. Data reported pursuant to this subdivision shall specify the covered persons that are being reported pursuant to subdivision (b).

(b) Commencing March 1, 2020, and at least annually thereafter, information specific to a multiple employer welfare arrangement (MEWA) shall be provided to the department, in a form and manner determined by the department in consultation with the Department of Managed Health Care, as follows:

(1) A health insurer that provides coverage through a MEWA that is not subject to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 shall provide the name of each MEWA and the number of covered persons in each MEWA as of December 31 of the prior year, divided by market segment and product type. Data reported pursuant to this subdivision shall be identified and separately reported under subdivision (a).

(2) A MEWA that is subject to Article 4.7 (commencing with Section 742.20) of Chapter 1 of Part 2 of Division 1 shall provide the number of covered persons in the MEWA as of December 31 of the prior year, divided by product type. Compliance with a data call issued pursuant to this section satisfies the requirements of this subdivision.

(c) The department shall publicly report the data provided by each health insurer and MEWA pursuant to this section, including, but not limited to, posting the data on the department's internet website. The department shall consult with the Department of Managed Health Care to ensure that the data reported is comparable and consistent, does not duplicate existing reporting requirements, and utilizes existing reporting formats. The data for the previous calendar year shall be made available no later than April 15 of each calendar year.

(Amended by Stats. 2020, Ch. 370, Sec. 217. (SB 1371) Effective January 1, 2021.)

10127.20. (a) Beginning on July 1, 2023, and annually thereafter, a health insurer offering a qualified health plan through the Exchange shall report to the commissioner the total amount of funds maintained in a segregated account pursuant to subdivision (a) of Section 1303 of the federal Patient Protection and Affordable Care Act (Public Law 111-148). This annual report shall contain the ending balance of the account and the total dollar amount of claims paid during the reporting year.

(b) For purposes of this section:

(1) "Exchange" means the California Health Benefit Exchange established pursuant to Title 22 (commencing with Section 100500) of the Government Code.

(2) "Qualified health plan" has the same meaning as defined in Section 1301 of the federal Patient Protection and Affordable Care Act (Public Law 111-148).

(Added by Stats. 2022, Ch. 563, Sec. 2. (AB 2205) Effective January 1, 2023.)