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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 4. Payment and Proceeds [10170 - 10180] (*Article 4 enacted by Stats. 1935, Ch. 145.*)

10170. Life insurance may be made payable as follows:

- (a) On the death of the insured.
- (b) On his or her surviving a specified period.
- (c) Periodically as long as he or she lives.
- (d) Otherwise contingently on the continuance or determination of life.
- (e) Upon those terms and conditions and subject to those restrictions as to revocation by the policyholder and control by beneficiaries as shall have been agreed to in writing by the insurer and the policyholder. If no terms and conditions have been agreed to by the insurer and the policyholder during the insured's lifetime then upon those terms and conditions and subject to those restrictions as may be agreed to in writing by the insurer and the beneficiaries. Any agreement may be rescinded or amended by the parties to the agreement without the consent of any designated beneficiary unless the rights of any beneficiary have been expressly declared to be irrevocable. No agreement hereafter made shall vest in the insurer discretion as to the conditions, time, amount, manner, or method of payment. The relationship between the insurer and the policyholder or beneficiaries under any agreement shall be that of debtor and creditor, and the insurer shall not be required to segregate funds so held but shall hold them as a part of its general corporate assets.
- (f) Notwithstanding subdivision (e), all life insurance benefits shall be paid in the form of a lump-sum payment to the beneficiary or by another settlement option that is clearly described in the claim form. If the beneficiary is provided settlement options in addition to a lump-sum payment or a settlement option selected by the policyholder, the beneficiary shall have the option to choose how benefits are to be paid to the beneficiary. If the beneficiary does not choose one of the available settlement options, a retained-asset account may be the default option only if the claim form provides a prominent disclosure that, in the absence of a choice by the beneficiary, payment of policy benefits shall be made through establishment of a retained-asset account on the beneficiary's behalf. This disclosure shall be provided in the portion of the claim form where the beneficiary is offered the ability to select his or her choice of payment method and shall be in easy-to-understand language and in bold and at least 12-point font type. In all such cases, whether by beneficiary choice or default, the insurer shall provide to the beneficiary the disclosure provided for in Section 10509.937.

(1) If an insurer offers an option or recommends the option to a policyholder of an individual or group life insurance policy that the beneficiary receive life insurance proceeds in the form of a retained-asset account or any arrangement other than a lump-sum payment, the insurer shall provide the policyholder, at the time the offer or recommendation is made, written information describing each of the settlement options available under the policy and specific details relevant to those options. If an insurer offers or recommends to a beneficiary that the beneficiary receive life insurance proceeds in the form of a retained-asset account or any arrangement other than a lump-sum payment in advance of the time the claim is made, the insurer shall provide the beneficiary written information describing each of the settlement options available under the policy and specific details relevant to those options. If an insurer offers or recommends to a beneficiary that the beneficiary receive life insurance proceeds in the form of a retained-asset account at the time a claim is being made, the insurer shall comply with the procedures set forth in Article 11 (commencing with Section 10509.930) of Chapter 5.

(2) For purposes of this subdivision, the following terms have the following meanings:

(A) "Lump-sum payment" means a single payment made directly to the beneficiary that satisfies all of the benefits owed to the beneficiary.

(B) "Retained-asset account" means any mechanism whereby the settlement of proceeds payable under a life insurance policy is accomplished by the insurer, or an entity acting on behalf of the insurer, by depositing those proceeds into an account with check or draft writing privileges, and where those proceeds are retained by the insurer pursuant to a supplemental contract not involving annuity benefits.

(g) An insurer that fails to conform to the requirements provided under this section shall be subject to Article 6.5 (commencing with Section 790) of Chapter 1 of Part 2 of Division 1.

(h) The commissioner may, from time to time and after notice and public hearing, adopt regulations specifying reasonable requirements for the form of agreements entered into and written disclosures provided pursuant to subdivisions (e) and (f), and for compliance with Section 10172.5.

(Amended by Stats. 2011, Ch. 423, Sec. 1. (SB 599) Effective January 1, 2012.)

10171. Any life policy or other agreement relating to the holding or payment of the proceeds of a life policy may provide that the proceeds thereof or payments thereunder shall not be subject to transfer, anticipation or commutation or encumbrance by any beneficiary, and shall not be subject to the claims of creditors of any beneficiary or any legal process against any beneficiary.

(Amended by Stats. 1943, Ch. 533.)

10172. Notwithstanding Sections 751 and 1100 of the Family Code and Section 249.5 of the Probate Code, when the proceeds of, or payments under, a life insurance policy become payable and the insurer makes payment thereof in accordance with the terms of the policy, or in accordance with the terms of any written assignment thereof if the policy has been assigned, that payment shall fully discharge the insurer from all claims under the policy unless, before that payment is made, the insurer has received, at its home office, written notice by or on behalf of some other person that the other person claims to be entitled to that payment or some interest in the policy.

(Amended by Stats. 2004, Ch. 775, Sec. 3. Effective January 1, 2005.)

10172.5. (a) Notwithstanding any other provision of law, each insurer admitted to transact life insurance, credit life insurance, or accidental death insurance in this state that fails or refuses to pay the proceeds of, or payments under, any policy of life insurance issued by it within 30 days after the date of death of the insured shall pay interest, at a rate not less than the then current rate of interest on death proceeds left on deposit with the insurer computed from the date of the insured's death, on any moneys payable and unpaid after the expiration of the 30-day period. This section shall apply only to deaths of insureds which occur on or after January 1, 1976.

(b) Nothing in this section shall be construed to allow any insurer admitted to transact life insurance, credit life insurance, or accidental death insurance in this state to withhold payment of money payable under a life insurance policy to any beneficiary for a period longer than reasonably necessary to transmit that payment. Whenever possible payment shall be made within 30 days after the date of death of the insured.

(c) In any case in which interest on the proceeds of, or payments under, any policy of life insurance, credit life insurance, or accidental death insurance becomes payable pursuant to subdivision (a), the insurer shall notify the named beneficiary or beneficiaries at their last known address that interest will be paid on the proceeds of, or payments under, that policy from the date of death of the named insured. That notice shall specify the rate of interest to be paid. In any case where the notice required by Section 249.5 of the Probate Code has been given to a life insurer, that insurer is not required to provide the notice required by this section until after it has been notified that a child has actually been born within two years of the death of the decedent. The obligation shall be deemed satisfied by giving notice to the person who first provides proof to the insurer that the child has been born alive.

(d) This section shall not require the payment of interest in any case in which the beneficiary elects in writing delivered to the insurer to receive the proceeds of, or payments under, the policy by any means other than a lump-sum payment thereof.

(Amended by Stats. 2004, Ch. 775, Sec. 4.5. Effective January 1, 2005.)

10173. When a policy of life insurance is assigned in writing the insurer may deal with the assignee in any manner not inconsistent with the terms of said assignment until the insurer has received at its home office written notice by or on behalf of some other person that such other person claims to be entitled to some interest in such policy.

(Added by Stats. 1941, Ch. 272.)

10173.2. When a policy of life insurance is, after the effective date of this section, assigned in writing as security for an indebtedness, the insurer shall, in any case in which it has received written notice of the name and address of the assignee, mail to the assignee a written notice, postage prepaid and addressed to the assignee's address filed with the insurer, not less than 30 days prior to the final lapse of the policy, each time the policy owner has failed or refused to transmit a premium payment to the insurer before the commencement of the policy's grace period or before the notice is mailed. The insurer shall give that notice to the

assignee in the proper case while the assignment remains in effect, unless the assignee has notified the insurer in writing that the notice is waived. The insurer shall be permitted to charge the policy owner directly or against the policy the reasonable cost of complying with this section, but in no event to exceed two dollars and fifty cents (\$2.50) for each notice.

As used in this section, "final lapse of the policy" means the date after which the policy will not be reinstated by the insurer without requiring evidence of insurability or written application.

(Amended by Stats. 2012, Ch. 315, Sec. 3. (AB 1747) Effective January 1, 2013.)

10174. Policies of disability insurance, as defined in Section 106, that provide for death benefits, shall, as to those death benefits, be subject to Sections 10172, 10172.5, and 10173.

(Amended by Stats. 2004, Ch. 601, Sec. 5. Effective January 1, 2005.)

10175. Nothing contained in Sections 10172, 10173 or 10174 shall affect any claim or right to any policy or the proceeds thereof, or payments thereunder, as between all persons other than the insurer.

(Added by Stats. 1941, Ch. 272.)

10175.5. (a) No disability insurance contract with a physician and surgeon, physician and surgeon group, or other licensed health care practitioner shall contain any incentive plan that includes specific payment made in any type or form, to a physician and surgeon, physician and surgeon group, or other licensed health care practitioner as an inducement to deny, reduce, limit, or delay specific, medically necessary, and appropriate services provided with respect to specific insureds or groups of insureds with similar medical conditions.

(b) Nothing in this section shall be construed to prohibit payment arrangements that are not tied to specific medical decisions involving specific insureds or group of insureds with similar medical conditions.

(Added by Stats. 1996, Ch. 1014, Sec. 4. Effective January 1, 1997.)

10176. (a) In disability insurance, the policy may provide for payment of medical, surgical, chiropractic, physical therapy, speech pathology, audiology, acupuncture, professional mental health, dental, hospital, or optometric expenses upon a reimbursement basis, or for the exclusion of any of those services, and provision may be made therein for payment of all or a portion of the amount of charge for these services without requiring that the insured first pay the expenses. The policy shall not prohibit the insured from selecting any psychologist or other person who is the holder of a certificate or license under Section 1000, 1634, 2050, 2472, 2553, 2630, 2948, 3055, or 4938 of the Business and Professions Code, to perform the particular services covered under the terms of the policy, the certificate holder or licensee being expressly authorized by law to perform those services.

(b) If the insured selects any person who is a holder of a certificate under Section 4938 of the Business and Professions Code, a disability insurer or nonprofit hospital service plan shall pay the bona fide claim of an acupuncturist holding a certificate pursuant to Section 4938 of the Business and Professions Code for the treatment of an insured person only if the insured's policy or contract expressly includes acupuncture as a benefit and includes coverage for the injury or illness treated. Unless the policy or contract expressly includes acupuncture as a benefit, no person who is the holder of any license or certificate set forth in this section shall be paid or reimbursed under the policy for acupuncture.

(c) The policy shall not prohibit the insured, upon referral by a physician and surgeon licensed under Section 2050 of the Business and Professions Code, from selecting any licensed clinical social worker who is the holder of a license issued under Section 4996 of the Business and Professions Code, any occupational therapist as specified in Section 2570.2 of the Business and Professions Code, any marriage and family therapist who is the holder of a license under Section 4980.50 of the Business and Professions Code, or any professional clinical counselor who is the holder of a license under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, to perform the particular services covered under the terms of the policy, or from selecting any speech-language pathologist or audiologist licensed under Section 2532 of the Business and Professions Code or any registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code who possesses a master's degree in psychiatric-mental health nursing and is listed as a psychiatric-mental health nurse by the Board of Registered Nursing, or any advanced practice registered nurse certified as a clinical nurse specialist pursuant to Article 9 (commencing with Section 2838) of Chapter 6 of Division 2 of the Business and Professions Code who participates in expert clinical practice in the specialty of psychiatric-mental health nursing, or any respiratory care practitioner certified pursuant to Chapter 8.3 (commencing with Section 3700) of Division 2 of the Business and Professions Code to perform services deemed necessary by the referring physician and surgeon, that certificate holder, licensee or otherwise regulated person, being expressly authorized by law to perform the services.

(d) Nothing in this section shall be construed to allow any certificate holder or licensee enumerated in this section to perform professional mental health services beyond his or her field or fields of competence as established by his or her education, training, and experience.

(e) For the purposes of this section:

(1) "Marriage and family therapist" means a licensed marriage and family therapist who has received specific instruction in assessment, diagnosis, prognosis, and counseling, and psychotherapeutic treatment of premarital, marriage, family, and child relationship dysfunctions, which is equivalent to the instruction required for licensure on January 1, 1981.

(2) "Professional clinical counselor" means a licensed professional clinical counselor who has received specific instruction in assessment, diagnosis, prognosis, counseling, and psychotherapeutic treatment of mental and emotional disorders, which is equivalent to the instruction required for licensure on January 1, 2012.

(f) An individual disability insurance policy, which is issued, renewed, or amended on or after January 1, 1988, which includes mental health services coverage may not include a lifetime waiver for that coverage with respect to any applicant. The lifetime waiver of coverage provision shall be deemed unenforceable.

(Amended by Stats. 2011, Ch. 381, Sec. 37. (SB 146) Effective January 1, 2012.)

10176.1. As of the effective date of the amendments to this section enacted at the 1969 Regular Session of the Legislature all disability policies shall be construed to be in compliance with Section 10176, and any provision in such policies in conflict therewith shall be of no effect.

(Amended by Stats. 1969, Ch. 296.)

10176.2. As an alternative to the exclusion permitted by Section 10176, a disability insurance policy may provide that services of a licensed physical therapist, licensed pursuant to Section 2630 of the Business and Professions Code, will be paid only if rendered pursuant to a method of treatment prescribed by a person holding a physician's and surgeon's certificate issued by the Medical Board of California.

(Amended by Stats. 1990, Ch. 886, Sec. 1.)

10176.25. (a) As an alternative to an exclusion permitted by Section 10176, a disability insurance policy may provide that services of a registered dietitian or other nutrition professional meeting the qualifications prescribed by subdivision (a) or (e) of Section 2585 of the Business and Professions Code will be paid only if rendered pursuant to a method of treatment prescribed by a person holding a physician's and surgeon's certificate issued by the Medical Board of California.

(b) Nothing in this section requires disability insurers to automatically pay for services provided by a registered dietitian or other nutrition professional.

(Amended by Stats. 2001, Ch. 628, Sec. 3. Effective January 1, 2002.)

10176.3. The amendments to Section 10176 and the addition of Section 10176.2 enacted at the 1971 Regular Session of the Legislature shall be applicable only to those policies issued or amended on or after the effective date of such amendments and addition.

(Added by Stats. 1971, Ch. 1490.)

10176.4. For purposes of establishing the fact of disability in credit disability insurance, disability insurance or life insurance, chiropractors' certifications of disability when made within the scope of their license shall be accepted by insurers as equally valid as physicians and surgeons' certifications of disability when made within the scope of their license.

(Added by Stats. 1977, Ch. 651.)

10176.5. Disability insurance which is written or issued for delivery outside California in a state the laws of which require recognition of psychologists licensed in such state for services performed within the scope of psychological practice shall not be deemed to prohibit the insured from selecting a psychologist licensed in California to perform services in California which are covered under the terms of the policy even though such psychologist is not licensed in the state in which the insurance is written or issued for delivery.

(Added by Stats. 1981, Ch. 558, Sec. 2.)

10176.6. On and after January 1, 1982, every policy of disability insurance which is issued, amended, delivered, or renewed that covers hospital, medical, or surgical expenses on a group basis shall offer coverage for diabetic daycare self-management education programs, under such terms and conditions as may be agreed upon between the insurer and the group policyholder, subject to utilization controls.

Coverage shall only apply to programs directed and supervised by a licensed physician who is board certified in internal medicine or pediatrics. Diabetic daycare self-management and education programs shall be provided by health care professionals including, but not limited to, physicians, registered nurses, registered pharmacists, and registered dietitians who are knowledgeable about the disease process of diabetes and the treatment of diabetic patients.

As used in this section, diabetic daycare self-management education programs means instruction which will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy thereby avoiding frequent hospitalizations and complications.

Nothing in this section shall be construed to require the offering of programs whose sole or primary purpose is weight reduction.

(Added by Stats. 1981, Ch. 750, Sec. 3.)

10176.61. (a) Every insurer issuing, amending, delivering, or renewing a disability insurance policy on or after January 1, 2000, that covers hospital, medical, or surgical expenses shall include coverage for the following equipment and supplies for the management and treatment of insulin-using diabetes, non-insulin-using diabetes, and gestational diabetes as medically necessary, even if the items are available without a prescription:

- (1) Blood glucose monitors and blood glucose testing strips.
- (2) Blood glucose monitors designed to assist the visually impaired.
- (3) Insulin pumps and all related necessary supplies.
- (4) Ketone urine testing strips.
- (5) Lancets and lancet puncture devices.
- (6) Pen delivery systems for the administration of insulin.
- (7) Podiatric devices to prevent or treat diabetes-related complications.
- (8) Insulin syringes.
- (9) Visual aids, excluding eyewear, to assist the visually impaired with proper dosing of insulin.

(b) Every insurer issuing, amending, delivering, or renewing a disability insurance policy on or after January 1, 2000, that covers prescription benefits shall include coverage for the following prescription items if the items are determined to be medically necessary:

- (1) Insulin.
- (2) Prescriptive medications for the treatment of diabetes.
- (3) Glucagon.

(c) The coinsurances and deductibles for the benefits specified in subdivisions (a) and (b) shall not exceed those established for similar benefits within the given policy.

(d) Every insurer shall provide coverage for diabetes outpatient self-management training, education, and medical nutrition therapy necessary to enable an insured to properly use the equipment, supplies, and medications set forth in subdivisions (a) and (b) and additional diabetes outpatient self-management training, education, and medical nutrition therapy upon the direction or prescription of those services by the insured's participating physician. If an insurer delegates outpatient self-management training to contracting providers, the insurer shall require contracting providers to ensure that diabetes outpatient self-management training, education, and medical nutrition therapy are provided by appropriately licensed or registered health care professionals.

(e) The diabetes outpatient self-management training, education, and medical nutrition therapy services identified in subdivision (d) shall be provided by appropriately licensed or registered health care professionals as prescribed by a health care professional legally authorized to prescribe the services.

(f) The coinsurances and deductibles for the benefits specified in subdivision (d) shall not exceed those established for physician office visits by the insurer.

(g) Every disability insurer governed by this section shall disclose the benefits covered pursuant to this section in the insurer's evidence of coverage and disclosure forms.

(h) An insurer may not reduce or eliminate coverage as a result of the requirements of this section.

(i) This section does 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, and hospital indemnity insurance coverage, benefits under this section only 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 may be construed as imposing a new benefit mandate on accident-only, specified disease, or hospital indemnity insurance.

(Amended by Stats. 2000, Ch. 135, Sec. 119. Effective January 1, 2001.)

10176.7. (a) Disability insurance where the insurer is licensed to do business in this state and which provides coverage under a contract of insurance which includes California residents but which may be written or issued for delivery outside of California where benefits are provided within the scope of practice of a licensed clinical social worker, a registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code who possesses a master's degree in psychiatric-mental health nursing and two years of supervised experience in psychiatric-mental health nursing, a marriage and family therapist who is the holder of a license under Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, a professional clinical counselor who is the holder of a license under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, or a respiratory care practitioner certified pursuant to Chapter 8.3 (commencing with Section 3700) of Division 2 of the Business and Professions Code shall not be deemed to prohibit persons covered under the contract from selecting those licensees in California to perform the services in California that are within the terms of the contract even though the licensees are not licensed in the state where the contract is written or issued for delivery.

(b) It is the intent of the Legislature in amending this section in the 1984 portion of the 1983–84 Legislative Session that persons covered by the insurance and those providers of health care specified in this section who are licensed in California should be entitled to the benefits provided by the insurance for services of those providers rendered to those persons.

(Amended by Stats. 2011, Ch. 381, Sec. 38. (SB 146) Effective January 1, 2012.)

10176.8. A disability insurance policy may provide that services of a respiratory care practitioner certified pursuant to Chapter 8.3 (commencing with Section 3700) of the Division 2 of the Business and Professions Code, will be paid for pulmonary rehabilitation and respiratory home care only if rendered pursuant to a method of treatment prescribed by a physician and surgeon.

(Added by Stats. 1989, Ch. 786, Sec. 3.)

10176.9. No policy, contract, or agreement coming within the provisions of this article, issued, entered into or renewed on or after July 1, 1984, shall be deemed to contain any provision restricting the liability of the insurer or plan with respect to expenses solely because the expenses were incurred while the person insured was in a state hospital, if the policy, contract, or agreement would have paid for the services but for the fact that they were provided in a state hospital. Nothing in this section shall be deemed to require an insurer or plan to pay a state hospital for covered expenses incurred by an insured or covered individual at a rate or charge higher than the insurer or plan would pay for such services to a hospital with which the insurer or plan has entered a contract providing for alternative rates of payment or limiting payments for services secured by insureds or covered individuals.

(Added by Stats. 1983, Ch. 796, Sec. 2. Effective September 14, 1983.)

10176.10. (a) On or after January 1, 1994, no disability insurer issuing policies covering hospital, surgical, or medical expenses delivered or renewed in this state or certificates of group disability insurance delivered or renewed in this state pursuant to a master group policy delivered or renewed in another state, to individuals, or to employer groups with fewer than two eligible employees, as defined in subdivision (g) of Section 10700, shall close a block of business without complying with this section.

(b) As used in this section, "block of business" means individual, group, or blanket disability insurance contracts covering hospital, medical, or surgical expenses of a particular policy form that has distinct benefits or marketing methods. "Closed block of business" means a block of business for which an insurer ceases to actively market and sell new contracts under a particular policy form in this state.

(c) Notwithstanding subdivision (b), a block of business shall be presumed closed if either of the following applies:

(1) There has been an overall reduction of 12 percent in the number of in force policies of a particular form for a period of 12 months.

(2) The block has less than 2,000 insured nationally or 1,000 insureds in California. This presumption shall not apply to a block of business initiated within the previous 24 months, but notification of that block shall be provided to the commissioner. The notification shall not be subject to the approval required by subdivision (d).

An insurer may present evidence for consideration by the commissioner that the presumption in the particular case is incorrect. Should the determination be made that the block is closed, the insurer shall be given those remedy options contained in subdivision (d). The fact that a block of business does not meet one of the presumptions set forth in this subdivision shall not preclude a determination that it is closed as defined in subdivision (b).

(d) An insurer shall notify the commissioner within 30 days of its decision to close a block or, in the absence of an actual decision to close a block of business, within 30 days of its determination that the block is within the presumptions set forth in subdivision (c). The

commissioner may notify an insurer that he or she has determined that the presumptions contained in subdivision (c) apply to a block. No insurer providing disability insurance covering hospital, medical, or surgical expenses shall close a policy form or group certificate without notification to the commissioner. That notification shall include a plan to permit an insured to move to any open block, providing comparable benefits with no additional underwriting requirement or, alternatively, the insurer shall be required to pool the closed block's experience with all appropriate open forms for purposes of renewal rate determination, with no rate penalty or surcharge, beyond that which reflects the experience of the combined pool. When the insurer chooses to pool, the notice shall include the insurer's plan for pooling the closed block's experience. The insurer may implement the pooling plan if 30 days expire after the submission is filed without written notice from the commissioner specifying the reasons for his or her opinion that the pooling plan does not comply with the requirements of this section, or, prior to that time, if the commissioner provides the insurer written notice that the pooling plan complies with the requirements of this section.

The approval shall be based upon consideration of the accumulative recent and expected future experience of the closed form and those with which the closed form is to be combined.

(e) No insurer shall offer or sell any form nor provide misleading information about the active or closed status of its business for the purpose of evading this section.

(f) An insurer shall bring any blocks of business closed prior to the effective date of this section into compliance with the terms of this section no later than December 31, 1994.

(g) This section shall not apply to small employer carriers providing small employer health insurance to individuals or employer groups with fewer than two eligible employees if that coverage is provided pursuant to Chapter 14 (commencing with Section 10700) of Part 2 of Division 2, and with specific reference to coverage for individuals or employer groups with fewer than two eligible employees, is approved by the commissioner pursuant to Section 10705, provided a carrier electing to sell coverage pursuant to this subdivision shall continue to do so until such time as the carrier ceases to market coverage to small employers and complies with subdivision (c) of Section 10713.

(h) This section shall not apply to accident only coverage, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, long-term care insurance, dental, vision, or conversion coverage, coverage issued as a supplement to liability insurance, or automobile medical payment insurance.

(Amended by Stats. 1997, Ch. 336, Sec. 27. Effective August 21, 1997.)

10176.11. (a) An insurer that provides a policy of health insurance shall accept premium payments from the following third-party entities without the need to comply with subdivision (c):

(1) A Ryan White HIV/AIDS Program under Title XXVI of the federal Public Health Service Act.

(2) An Indian tribe, tribal organization, or urban Indian organization.

(3) A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.

(4) A member of the individual's family, defined for purposes of this section to include the individual's spouse, domestic partner, child, parent, grandparent, and siblings, unless the true source of funds used to make the premium payment originates with a financially interested entity.

(b) A financially interested entity that is not specified in subdivision (a) and is making third-party premium payments shall comply with all of the following requirements:

(1) It shall provide assistance for the full policy year and notify the insured prior to an open enrollment period, if applicable, if financial assistance will be discontinued. Notification shall include information regarding alternative coverage options, including, but not limited to, Medicare, Medicaid, individual market policies, and employer policies, if applicable. Assistance may be discontinued at the request of an insured who obtains other health insurance coverage, or if the insured dies during the policy year.

(2) It shall agree not to condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device.

(3) It shall inform an applicant of financial assistance, and shall inform an insured annually, of all available health coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable.

(4) It shall agree not to steer, direct, or advise the insured into or away from a specific coverage program option or health coverage.

(5) It shall agree that financial assistance shall not be conditioned on the use of a specific facility, health care provider, or coverage type.

(6) It shall agree that financial assistance shall be based on financial need in accordance with criteria that are uniformly applied and publicly available.

(c) A financially interested entity shall not make a third-party premium payment unless the entity complies with both of the following requirements:

(1) Annually provides a statement to the health insurer that it meets the requirements set forth in subdivision (b), as applicable.

(2) Discloses to the health insurer, prior to making the initial payment, the name of the insured for each policy on whose behalf a third-party premium payment described in this section will be made.

(d) (1) Reimbursement for insureds for whom a nonprofit financially interested entity described in paragraph (2) of subdivision (h) that was already making premium payments to a health insurer on the insured's behalf prior to October 1, 2019, is not subject to subdivisions (e) and (f) and the financially interested entity is not required to comply with the disclosure requirements described in subdivision (c) for those insureds.

(2) Notwithstanding paragraph (1), a financially interested entity shall comply with the disclosure requirements of subdivision (c) for an insured on whose behalf the financially interested entity was making premium payments to a health insurer on the insured's behalf prior to October 1, 2019, if the insured changes health insurers on or after March 1, 2020.

(3) The amount of reimbursement for services paid to a financially interested provider shall be governed by the terms of the insured's health insurance policy contract, except for an insured who has changed health insurers pursuant to paragraph (2), in which case, commencing January 1, 2022, the reimbursement amount shall be determined in accordance with subdivisions (e) and (f).

(e) Commencing January 1, 2022, if a financially interested entity makes a third-party premium payment to a health insurer on behalf of an insured, reimbursement to a financially interested provider for covered services shall be determined by the following:

(1) For a contracted financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the insured shall be governed by the higher of the Medicare reimbursement or the rate determined pursuant to the process described in this subdivision, if a rate determination pursuant to that process is sought by either the provider or the health insurer. Financially interested providers shall neither bill the insured nor seek reimbursement from the insured for services provided, except for cost sharing pursuant to the terms and conditions of the insured's health insurance policy. If an insured's policy imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health insurer pursuant to this paragraph.

(2) For a noncontracting financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the insured shall be governed by the terms and conditions of the insured's health insurance policy or the rate determined pursuant to the process described in this subdivision, whichever is lower, if a rate determination pursuant to that process is sought by either the provider or the health insurer. Financially interested providers shall not bill the insured nor seek reimbursement from the insured for services provided, except for cost sharing pursuant to the terms and conditions of the insured's health insurance policy. If the insured's policy imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health insurer pursuant to this paragraph. A claim submitted to a health insurer by a noncontracting financially interested provider may be considered an incomplete claim and contested by the health insurer pursuant to Section 10123.13 or 10123.147 if the financially interested provider has not provided the information as required in subdivision (c).

(f) (1) By October 1, 2021, the department shall establish an independent dispute resolution process for the purpose of determining if the amount required to be reimbursed by subdivision (e) is appropriate.

(2) If either the provider or health insurer submits a claim to the department's independent dispute resolution process, the other party shall participate in the independent dispute resolution process.

(3) In making its determination, the independent organization shall consider information submitted by either party regarding the actual cost to provide services, patient eligibility for Medicare or Medi-Cal, and the rate that would be paid by Medicare or Medi-Cal for patients eligible for those programs.

(4) The health insurer shall implement the determination obtained through the independent dispute resolution process. The independent organization's determination of the amount required to be reimbursed shall apply for the duration of the policy year for that insured. If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law.

(5) In establishing the independent dispute resolution process, the department shall permit the bundling of claims submitted to the same insurer or the same delegated entity for the same or similar services. The department shall permit claims on behalf of multiple insureds from the same provider to the same health insurer to be combined into a single independent dispute resolution process.

(6) The department 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.

(7) The department shall establish reasonable and necessary fees not to exceed the reasonable costs of administering this subdivision.

(8) The department 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.

(9) The department shall use conflict-of-interest standards consistent with the standards pursuant to subdivisions (c) and (d) of Section 10169.2.

(10) The department may contract with the same independent organization or organizations as the Department of Managed Health Care.

(11) The independent organization retained to conduct proceedings shall be deemed to be consultants for purposes of Section 43.98 of the Civil Code.

(12) 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 Title 2 of the Government Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(13) This subdivision does not alter a health insurer's obligations under Section 10123.13.

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

(g) For the purposes of this section, third-party premium payments only include health insurance premium payments made directly by a provider or other third party, made indirectly through payments to the individual for the purpose of making health insurance premium payments, or provided to one or more intermediaries with the intention that the funds be used to make health insurance premium payments for the individuals.

(h) The following definitions apply for purposes of this section:

(1) "Financially interested" includes any of the following entities:

(A) A provider of health care services that receives a direct or indirect financial benefit from a third-party premium payment.

(B) An entity that receives the majority of its funding from one or more financially interested providers of health care services, parent companies of providers of health care services, subsidiaries of health care service providers, or related entities.

(C) A chronic dialysis clinic that is operated, owned, or controlled by a parent entity or related entity that meets the definition of a large dialysis clinic organization (LDO) under the federal Centers for Medicare and Medicaid Services Comprehensive ESRD Care Model as of January 1, 2019. A chronic dialysis clinic that does not meet the definition of an LDO or has no more than 10 percent of California's market share of licensed chronic dialysis clinics shall not be considered financially interested for purposes of this section.

(2) "Health insurance" means an individual or group health insurance policy as defined in subdivision (b) of Section 106. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, or specialized health insurance coverage as described in subdivision (c) of Section 106.

(3) "Insured" means an individual whose health insurance premiums are paid by a financially interested entity.

(4) "Provider" means a professional person, organization, health facility, or other person or institution that delivers or furnishes health care services.

(i) The following shall occur if a health insurer subsequently discovers that a financially interested entity fails to provide disclosure pursuant to subdivision (c):

(1) The health insurer shall be entitled to recover 120 percent of the difference between payment made to a provider and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference.

(2) The health insurer shall notify the department of the amount by which the provider was overpaid and shall remit to the department any amount exceeding the difference between the payment made to the provider and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference that was recovered pursuant to paragraph (1).

(j) Commencing January 1, 2022, each health insurer licensed by the department and subject to this section shall provide to the department information regarding premium payments by financially interested entities and reimbursement for services to providers under subdivision (e). The information shall be provided at least annually at the discretion of the department and shall include, to the best of the health insurer's knowledge, the number of insureds whose premiums were paid by financially interested entities, disclosures provided to the insurer pursuant to subdivision (c), the identities of any providers whose reimbursement rate was governed by subdivision (e), the identities of any providers who failed to provide disclosure as described in subdivision (c), and, at the discretion of the department, additional information necessary for the implementation of this section.

(k) This section does not limit the authority of the Attorney General to take action to enforce this section.

(l) This section does not affect a contracted payment rate for a provider who is not financially interested.

(m) This section does not alter any of a health insurer's obligations and requirements under this part, including, but not limited to, the following:

(1) The obligation of a health insurer to fairly and affirmatively offer, market, sell, and issue a health benefit plan to any individual, consistent with Chapter 9.9 (commencing with Section 10965), or small employer, consistent with Chapter 8 (commencing with Section 10700).

(2) The obligations of a health insurer with respect to cancellation or nonrenewal as provided in this part, including, but not limited to, Sections 10273.4, 10273.6, and 10273.7.

(3) A health insurer may not deny coverage to an insured whose premiums are paid by a third party.

(n) This section does not supersede or modify any privacy and information security requirements and protections in federal and state law regarding protected health information or personally identifiable information, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).

(o) Notwithstanding clause (iii) of subparagraph (A) of paragraph (1) of subdivision (d) of Section 10965.3, an insured's loss of coverage due to a financially interested entity's failure to pay premiums on a timely basis shall be deemed a triggering event for special enrollment pursuant to subparagraph (A) of paragraph (1) of subdivision (d) of Section 10965.3.

(Amended by Stats. 2020, Ch. 370, Sec. 218. (SB 1371) Effective January 1, 2021.)

10177. (a) A self-insured employee welfare benefit plan may provide for payment of professional mental health expenses upon a reimbursement basis, or for the exclusion of those services, and provision may be made therein for payment of all or a portion of the amount of charge for those services without requiring that the employee first pay those expenses. The plan shall not prohibit the employee from selecting any psychologist who is the holder of a certificate issued under Section 2948 of the Business and Professions Code or, upon referral by a physician and surgeon licensed under Section 2135 of the Business and Professions Code, any licensed clinical social worker who is the holder of a license issued under Section 4996 of the Business and Professions Code or any marriage and family therapist who is the holder of a certificate or license under Section 4980.50 of the Business and Professions Code, any professional clinical counselor who is the holder of a license under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, or any registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code, who possesses a master's degree in psychiatric-mental health nursing and is listed as a psychiatric-mental health nurse by the Board of Registered Nursing or any advanced practice registered nurse certified as a clinical nurse specialist pursuant to Article 9 (commencing with Section 2838) of Chapter 6 of Division 2 of the Business and Professions Code who participates in expert clinical practice in the specialty of psychiatric-mental health nursing, to perform the particular services covered under the terms of the plan, the certificate or license holder being expressly authorized by law to perform these services.

(b) Nothing in this section shall be construed to allow any certificate holder or licensee enumerated in this section to perform professional services beyond his or her field or fields of competence as established by his or her education, training, and experience.

(c) For the purposes of this section:

(1) "Marriage and family therapist" shall mean a licensed marriage and family therapist who has received specific instruction in assessment, diagnosis, prognosis, and counseling, and psychotherapeutic treatment of premarital, marriage, family, and child relationship dysfunctions, which is equivalent to the instruction required for licensure on January 1, 1981.

(2) "Professional clinical counselor" means a licensed professional clinical counselor who has received specific instruction in assessment, diagnosis, prognosis, counseling, and psychotherapeutic treatment of mental and emotional disorders, which is equivalent to the instruction required for licensure on January 1, 2012.

(d) A self-insured employee welfare benefit plan, which is issued, renewed, or amended on or after January 1, 1988, that includes mental health services coverage in nongroup contracts may not include a lifetime waiver for that coverage with respect to any employee. The lifetime waiver of coverage provision shall be deemed unenforceable.

(Amended by Stats. 2011, Ch. 381, Sec. 39. (SB 146) Effective January 1, 2012.)

10177.5. A self-insured employee welfare benefit plan which is written or issued for delivery outside California in a state the laws of which require recognition of psychologists licensed in such state for services performed within the scope of psychological practice shall not be deemed to prohibit the insured from selecting a psychologist licensed in California to perform services in California which are covered under the terms of the policy even though such psychologist is not licensed in the state in which the insurance is written or issued for delivery.

(Added by Stats. 1981, Ch. 558, Sec. 3.)

10177.6. On and after the effective date of this section, a self-insured employee welfare benefit plan shall not prohibit the insured from selecting any person who is the holder of a certificate or license under Section 3055 of the Business and Professions Code to perform the particular services covered under the terms of the plan, such certificate holder or licensee being expressly authorized by law to perform such services.

This section shall not apply to any plan governed by federal law which expressly preempts state regulation.

(Added by Stats. 1981, Ch. 1032, Sec. 1.)

10177.7. On and after January 1, 1982, every self-insured employee welfare benefit plan which is issued, amended, delivered, or renewed that covers hospital, medical, or surgical expenses on a group basis shall offer coverage for diabetic daycare self-management education programs, under such terms and conditions as may be agreed upon between the plan and the group policyholder, subject to utilization controls.

Coverage shall only apply to programs directed and supervised by a licensed physician who is board certified in internal medicine or pediatrics. Covered diabetic daycare self-management and education programs shall be provided by health care professionals including, but not limited to, physicians, registered nurses, registered pharmacists, and registered dietitians who are knowledgeable about the disease process of diabetes and the treatment of diabetic patients.

As used in this section, diabetic daycare self-management education programs means instruction which will enable diabetic patients and their families to gain an understanding of the diabetic disease process, and the daily management of diabetic therapy thereby avoiding frequent hospitalizations and complications.

Nothing in this section shall be construed to require the offering of programs whose sole or primary purpose is weight reduction.

(Added by Stats. 1981, Ch. 750, Sec. 4.)

10177.8. (a) A self-insured employee welfare benefit plan doing business in this state and providing coverage that includes California residents but that may be written or issued for delivery outside of California where benefits are provided within the scope of practice of a licensed clinical social worker, a registered nurse licensed pursuant to Chapter 6 (commencing with Section 2700) of Division 2 of the Business and Professions Code who possesses a master's degree in psychiatric-mental health nursing and two years of supervised experience in psychiatric-mental health nursing, a marriage and family therapist who is the holder of a license under Chapter 13 (commencing with Section 4980) of Division 2 of the Business and Professions Code, or a professional clinical counselor who is the holder of a license under Chapter 16 (commencing with Section 4999.10) of Division 2 of the Business and Professions Code, shall not be deemed to prohibit persons covered under the plan from selecting those licensees in California to perform the services in California that are within the terms of the contract even though the licensees are not licensed in the state where the contract is written or issued.

(b) It is the intent of the Legislature in amending this section in the 1984 portion of the 1983–84 Legislative Session that persons covered by the plan and those providers of health care specified in this section who are licensed in California should be entitled to the benefits provided by the plan for services of those providers rendered to those persons.

(Amended by Stats. 2011, Ch. 381, Sec. 40. (SB 146) Effective January 1, 2012.)

10177.9. (a) It is the intent of the Legislature that all persons licensed in this state to engage in the practice of dentistry shall be accorded equal professional status and privileges, without regard to the degree earned.

(b) Notwithstanding any other provision of law, no nonprofit hospital service plan or self-insured employee welfare benefit plan shall discriminate, with respect to employment, staff privileges, or the provision of, or contracts for, professional services, against a

licensed dentist solely on the basis of the educational degree held by the dentist.

(Added by Stats. 1991, Ch. 729, Sec. 3.)

10178. No admitted insurer, union trust fund which administers health, medical, or surgical insurance, or employer which has an insurance company administering its health services program, shall deny, for the reason that the insured incurred no expense, a claim for hospital, medical or surgical services rendered by a nongovernmental charitable research hospital in this state which makes no charge for its services in the absence of insurance. No expense-incurred, group hospital, medical or surgical policy or certificate or union trust fund which administers health, medical, or surgical insurance, or employer which has an insurance company administering its health services program, shall except, limit or reduce benefits for services rendered by a nongovernmental charitable research hospital because it does not charge for its services in the absence of insurance. No expense-incurred individual hospital, medical or surgical policy or certificate or union trust fund which administers health, medical, or surgical insurance, or employer which has an insurance company administering its health services program, shall except, limit, or reduce benefits for services rendered by a nongovernmental charitable research hospital because it does not charge for its services in the absence of insurance.

This section shall apply to every group policy or certificate of expense-incurred hospital, medical, or surgical insurance covering or delivered to a covered individual in this state, notwithstanding the situs of the group master policy pursuant to which the coverage is provided.

As used in this section, charitable research hospital means a hospital that meets all the following criteria:

- (1) Is internationally recognized as devoting itself primarily to medical research.
- (2) Expends not less than 10 percent of its operating budget in each fiscal year exclusively on medical research activities which are not directly related to the provision of services to patients.
- (3) Derives not less than one-third of its gross revenues in each fiscal year from contributions, donations, grants, gifts, or other gratuitous forms from individuals, groups, persons, or entities unrelated to the hospital. Contributions, donations, grants, gifts or other gratuitous sources of revenue received as compensation for medical services provided patients shall not be considered for purposes of this subdivision.
- (4) Accepts patients without regard to the patient's ability to pay for medical services.
- (5) Not less than two-thirds of the patients admitted have a primary diagnosis or suspected disease or condition directly related to the specific area or areas in which the hospital conducts research. Patients admitted because of an emergent life-threatening condition who could not be safely transported to another hospital shall not be considered as patients for purposes of this section.

(Amended by Stats. 1982, Ch. 579, Sec. 1.)

10178.3. (a) In order to prevent the improper selling, leasing, or transferring of a health care provider's contract, it is the intent of the Legislature that every arrangement that results in a payor paying a health care provider a reduced rate for health care services based on the health care provider's participation in a network or panel shall be disclosed to the provider in advance and that the payor shall actively encourage beneficiaries to use the network, unless the health care provider agrees to provide discounts without that active encouragement.

(b) Beginning July 1, 2000, every contracting agent that sells, leases, assigns, transfers, or conveys its list of contracted health care providers and their contracted reimbursement rates to a payor, as defined in subparagraph (A) of paragraph (3) of subdivision (d), or another contracting agent shall, upon entering or renewing a provider contract, do all of the following:

- (1) Disclose whether the list of contracted providers may be sold, leased, transferred, or conveyed to other payors or other contracting agents, and specify whether those payors or contracting agents include workers' compensation insurers or automobile insurers.
- (2) Disclose what specific practices, if any, payors utilize to actively encourage a payor's beneficiaries to use the list of contracted providers when obtaining medical care that entitles a payor to claim a contracted rate. For purposes of this paragraph, a payor is deemed to have actively encouraged its beneficiaries to use the list of contracted providers if one of the following occurs:

(A) The payor's contract with subscribers or insureds offers beneficiaries direct financial incentives to use the list of contracted providers when obtaining medical care. "Financial incentives" means reduced copayments, reduced deductibles, premium discounts directly attributable to the use of a provider panel, or financial penalties directly attributable to the nonuse of a provider panel.

(B) The payor provides information to its beneficiaries, who are parties to the contract, or, in the case of workers' compensation insurance, the employer, advising them of the existence of the list of contracted providers through the use of a variety of advertising or marketing approaches that supply the names, addresses, and telephone numbers of contracted providers to beneficiaries in advance of their selection of a health care provider, which approaches may include, but are not limited to, the use of provider directories, or the use of toll-free telephone numbers or Internet Web site addresses supplied directly to every beneficiary. However, Internet Web site addresses alone shall not be deemed to satisfy the requirements of this subparagraph. Nothing in this subparagraph shall prevent contracting agents or payors from providing only listings of providers located within a reasonable geographic range of a beneficiary.

(3) Disclose whether payors to which the list of contracted providers may be sold, leased, transferred, or conveyed may be permitted to pay a provider's contracted rate without actively encouraging the payors' beneficiaries to use the list of contracted providers when obtaining medical care. Nothing in this subdivision shall be construed to require a payor to actively encourage the payor's beneficiaries to use the list of contracted providers when obtaining medical care in the case of an emergency.

(4) Disclose, upon the initial signing of a contract, and within 30 calendar days of receipt of a written request from a provider or provider panel, a payor summary of all payors currently eligible to claim a provider's contracted rate due to the provider's and payor's respective written agreements with any contracting agent.

(5) Allow providers, upon the initial signing, renewal, or amendment of a provider contract, to decline to be included in any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care as described in paragraph (2). Each provider's election under this paragraph shall be binding on the contracting agent with which the provider has a contract and any other contracting agent that buys, leases, or otherwise obtains the list of contracted providers. A provider shall not be excluded from any list of contracted providers that is sold, leased, transferred, or conveyed to payors that actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care, based upon the provider's refusal to be included on any list of contracted providers that is sold, leased, transferred, or conveyed to payors that do not actively encourage the payors' beneficiaries to use the list of contracted providers when obtaining medical care.

(6) Nothing in this subdivision shall be construed to impose requirements or regulations upon payors, as defined in subparagraph (A) of paragraph (3) of subdivision (d).

(c) Beginning July 1, 2000, a payor, as defined in subparagraph (B) of paragraph (3) of subdivision (d), shall do all of the following:

(1) Provide an explanation of benefits or explanation of review that identifies the name of the network that has a written agreement signed by the provider whereby the payor is entitled, directly or indirectly, to pay a preferred rate for the services rendered.

(2) Demonstrate that it is entitled to pay a contracted rate within 30 business days of receipt of a written request from a provider who has received a claim payment from the payor. The failure of a payor to make the demonstration within 30 business days shall render the payor responsible for the amount that the payor would have been required to pay pursuant to the beneficiary's policy with the payor, which amount shall be due and payable within 10 business days of receipt of written notice from the provider, and shall bar the payor from taking any future discounts from that provider without the provider's express written consent until the payor can demonstrate to the provider that it is entitled to pay a contracted rate as provided in this subdivision. A payor shall be deemed to have demonstrated that it is entitled to pay a contracted rate if it complies with either of the following:

(A) Discloses the name of the network that has a written agreement with the provider whereby the provider agrees to accept discounted rates, and describes the specific practices the payor utilizes to comply with paragraph (2) of subdivision (b).

(B) Identifies the provider's written agreement with a contracting agent whereby the provider agrees to be included on lists of contracted providers sold, leased, transferred, or conveyed to payors that do not actively encourage beneficiaries to use the list of contracted providers pursuant to paragraph (5) of subdivision (b).

(d) For the purposes of this section, the following terms have the following meanings:

(1) "Beneficiary" means:

(A) For automobile insurance, those persons covered under the medical payments portion of the insurance contract.

(B) For group or individual health services covered through a health care service plan contract, including a specialized health care service plan contract, or a policy of disability insurance that covers hospital, medical, or surgical benefits, a subscriber, an enrollee, a policyholder, or an insured.

(C) For workers' compensation insurance, an employee seeking health care services for a work-related injury.

(2) "Contracting agent" means an insurer licensed under this code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, or workers' compensation insurance, while engaged, for monetary or other consideration,

in the act of selling, leasing, transferring, assigning, or conveying a provider or provider panel to provide health care services to beneficiaries.

(3) (A) For the purposes of subdivision (b), "payor" means a health care service plan, including a specialized health care service plan, an insurer licensed under this code to provide disability insurance that covers hospital, medical, or surgical benefits, automobile insurance, or workers' compensation insurance, or a self-insured employer that is responsible to pay for health care services provided to beneficiaries.

(B) For the purposes of subdivision (c), "payor" means only an insurer licensed under this code to provide disability insurance that covers hospital, medical, or surgical benefits, or automobile insurance, if that insurer is responsible to pay for health care services provided to beneficiaries.

(4) "Payor summary" means a written summary that includes the payor's name and the type of plan, including, but not limited to, a group health plan, an automobile insurance plan, and a workers' compensation insurance plan.

(5) "Provider" means any of the following:

(A) Any person licensed or certified pursuant to Division 2 (commencing with Section 500) of the Business and Professions Code.

(B) Any person licensed pursuant to the Chiropractic Initiative Act or the Osteopathic Initiative Act.

(C) Any person licensed pursuant to Chapter 2.5 (commencing with Section 1440) of Division 2 of the Health and Safety Code.

(D) A clinic, health dispensary, or health facility licensed pursuant to Division 2 (commencing with Section 1200) of the Health and Safety Code.

(E) Any entity exempt from licensure pursuant to Section 1206 of the Health and Safety Code.

(e) This section shall become operative on July 1, 2000.

(Amended by Stats. 2001, Ch. 159, Sec. 145. Effective January 1, 2002.)

10178.4. (a) When a contracting agent sells, leases, or transfers a health provider's contract to a payor, the rights and obligations of the provider shall be governed by the underlying contract between the health care provider and the contracting agent.

(b) For purposes of this section, the following terms shall have the following meanings:

(1) "Contracting agent" has the meaning set forth in paragraph (2) of subdivision (d) of Section 10178.3.

(2) "Payor" has the meaning set forth in paragraph (3) of subdivision (d) of Section 10178.3.

(Amended by Stats. 2004, Ch. 183, Sec. 246. Effective January 1, 2005.)

10178.5. (a) Every self-insured employee welfare benefit plan issued, amended, or renewed on and after January 1, 1987, that offers coverage for medical transportation services, shall contain a provision providing for direct reimbursement to any provider of covered medical transportation services if the provider has not received payment for those services from any other source.

(b) Subdivision (a) shall not apply to any transaction between a provider of medical transportation services and a self-insured employee welfare benefit plan if the parties have entered into a contract providing for direct payment.

(c) For purposes of this subdivision, "direct reimbursement" means the following:

The insured shall file a claim for the medical transportation service with the plan; the plan shall pay the medical transportation provider directly; and the medical transportation provider shall not demand payment from the insured until having received payment from the plan, at which time the medical transportation provider may demand payment from the insured for any unpaid portion of the provider's fee.

(Added by Stats. 1986, Ch. 930, Sec. 2.)

10179. A disability insurer that offers or provides coverage for any services that are legally within the scope of the practice of podiatric medicine, as defined in Section 2472 of the Business and Professions Code, as a specific plan benefit or otherwise, shall not refuse to give reasonable consideration to negotiating contracts with or affiliation with podiatrists for the provision of service solely on the basis that they are podiatrists.

(Amended by Stats. 1992, Ch. 981, Sec. 7. Effective January 1, 1993.)

10180. (a) A disability insurer which negotiates and enters into a contract with professional providers to provide services at alternative rates of payment pursuant to Section 10133 of the Insurance Code, shall give reasonable consideration to timely written proposals for contracting by licensed or certified professional providers.

(b) For the purposes of this section, the following definitions are applicable:

(1) "Reasonable consideration" means consideration in good faith of the terms of proposals for contracting prior to the time that contracts for alternative rates of payment are entered into or renewed. An insurer may specify the terms and conditions of contracting to assure cost efficiency, qualification of providers, appropriate utilization of services, accessibility, convenience to persons who would receive the provider's services, and consistency with its basic method of operation, but shall not exclude providers because of their category of license.

(2) "Professional provider" means a holder of a certificate or license under Division 2 (commencing with Section 500) of the Business and Professions Code, or any initiative act referred to therein, except for those certified or licensed pursuant to Article 3 of Chapter 5 (commencing with Section 2050) or Chapter 11 (commencing with Section 4800), who may, within the scope of their licenses, perform the services of a specific benefit defined in the insurer's policy.

(c) An insurer which has a contract with an institutional provider or with professional providers is not required by this section to give consideration to contracting with professional providers who hold the same category of license or certificate and propose to serve a geographic area served adequately by the contracting providers that provide their professional services as employees or agents of that institutional or professional provider, or contract with that institutional or professional provider to provide professional services.

(Added by Stats. 1984, Ch. 977, Sec. 2.)