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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 4. Standard Provisions in Disability Policies [10270 - 10402.1] (*Chapter 4 enacted by Stats. 1935, Ch. 145.*)

ARTICLE 1. Scope of Chapter and Definitions [10270 - 10279] (*Article 1 enacted by Stats. 1935, Ch. 145.*)

10270. (a) This chapter shall not apply to workers' compensation insurance, any policy of liability insurance with or without supplementary coverage, or any policy or contract of reinsurance.

(b) This chapter shall apply to selected group disability insurance as defined in Section 10270.97, except insofar as it is exempted from Section 10401.

(c) This chapter shall apply to each of the types of insurance enumerated in this subdivision that insure more than one person, except to the extent that the type of insurance may be exempted from compliance with particular portions of this chapter by the provisions of this chapter relating to that type of insurance.

The types of insurance that insure more than one person and that are hereby exempted from subdivision (c) of Section 10320 (but family expense disability insurance only to the extent therein provided), and Section 10401 (but only to the extent in this chapter provided) are:

- (1) Blanket insurance, as defined in subdivision (a) of Section 10270.2.
- (2) Tuition refund insurance, as defined in Section 10270.1.
- (3) Group disability insurance, as defined in Sections 10270.5, 10270.505, and 10270.57.
- (4) Family expense disability insurance, as defined in Section 10270.7.
- (5) Unemployment compensation disability insurance, as defined in paragraph (6) of subdivision (a) of Section 10270.2.

(Amended by Stats. 2018, Ch. 231, Sec. 15. (AB 2045) Effective January 1, 2019.)

10270.1. (a) As used in this section:

- (1) "Institution" means any school, college or other institution of learning or the principal or head thereof.

"Camp" means one or more tents, vehicles, buildings or structures together with the tract of land appertaining thereto, established or maintained as living quarters for temporary occupancy by 10 or more people, and shall include the principal or head thereof.

- (2) "Student" means any student or pupil or his parent, guardian or other person who pays or becomes obligated to pay the tuition or fee required for registration or attendance at the institution.

"Camper" means any person or his parent, guardian or other person who pays or becomes obligated to pay the tuition or fee required for registration or attendance at the camp.

- (3) "Tuition refund insurance" means any policy which, because of a student's or camper's absence from, or inability to register at or attend, an institution or camp, as the case may be, provides for the indemnification of the student or camper for his loss of tuition or fee, or if he has been previously indemnified therefor by the institution or camp, for its reimbursement.

(b) Except to the extent provided herein, the other sections of this chapter shall not apply to tuition refund insurance providing coverage for ten (10) or more students or campers.

(c) No policy of tuition refund insurance shall be delivered or issued for delivery to any person in this State unless approved as to substance and form by the commissioner. The commissioner may, after notice and hearing, promulgate such reasonable rules and regulations, relating to the substance, form and issuance of such policies, as are necessary or desirable to preserve, insofar as applicable, standards as respects substance, form and issuance comparable to the standards in such respects prescribed by this chapter and applicable to disability policies, and to further the purpose or purposes for which such policies are to be issued.

(d) Tuition refund insurance may be issued only to an institution or camp which does not have a similar policy in effect, but its cost may be borne by the student or camper, as the case may be, in which event he may, upon request, obtain from the insurer a copy of the policy.

(Amended by Stats. 1957, Ch. 1558.)

10270.2. (a) Blanket insurance is that form of insurance providing coverage for specified circumstances and insuring by description all or nearly all persons within a class of persons defined in a policy issued to a master policyholder, and not by specifically naming the persons covered, by certificate or otherwise, although a statement of the coverage provided may be given, or required by the policy to be given, to eligible persons. The permitted types of blanket insurance are those where the blanket policy is issued to any of the following:

(1) A volunteer or governmental fire department, emergency medical services company, or similar volunteer or governmental organization providing benefits to members or participants only in the event of accident incurred while performing actions incident to an activity or operation sponsored or supervised by the department, company, or organization.

(2) A college, school, or other institution of learning, a school district or districts or school jurisdictional unit, or to the head, principal, or governing board of an educational unit who or which shall be deemed the policyholder; providing benefits to students without necessarily any restriction as to activity, time, or place, or to teachers or employees while performing actions incident to special duties, such as at camps, at summer playgrounds, or during tours or excursions; and providing benefits to students, teachers, or employees, and spouses and dependents of students, teachers, and employees, for death or dismemberment resulting from accident, or for hospital, medical, surgical, drug, or nursing expenses resulting from accident or sickness.

(3) A sports team, camp, or sponsor, or proprietor thereof, who shall be deemed the policyholder, providing benefits to sports team participants, campers, employees, officials, supervisors, or persons responsible for their support, for death or dismemberment resulting from accident or for hospital, medical, surgical, or nursing expenses resulting from accident, to those participants, campers, employees, officials, supervisors, or persons responsible for their support, or arising out of sickness of those participants, campers, employees, officials, supervisors, or persons responsible for their support, provided the accident or the first manifestation of sickness occurs while those participants, campers, employees, officials, supervisors, or persons responsible for their support are in or on the buildings or premises of the sports team or camp, or being transported between their homes and the sports team or camp, or while at any other place as an incident to sports team- or camp-sponsored activities or while being transported to, from, or between those places.

(4) (A) A newspaper, farm paper, magazine, or other periodical publication, which shall be deemed the policyholder, providing benefits for independent contractors, such as carriers, newsboys, dealers, distributors, wholesalers, or others engaged in the sale, distribution, collecting for, or other activities pertaining to the marketing and delivery of the publication, including attendance at a coaching school or participation as a member of a trip organized, supervised, and sponsored as a reward for meritorious service, on account of loss resulting from accident or sickness, the benefit to be payable to the independent contractors or to their parents, guardians, or other persons responsible for their support.

(B) When the premium for the insurance is paid by the person insured, he or she may, upon request, obtain from the insurer in certificate form a copy of the policy.

(5) Any religious, charitable, recreational, educational, athletic, or civic organization, or branch thereof, which shall be deemed the policyholder, providing benefits to any group of members, employees, or participants for death or dismemberment or for hospital, medical, surgical, or nursing expenses resulting from accident incurred incident to specific hazards pertaining to any activity or activities or operations sponsored or supervised by, or on the premises of, the policyholder.

(6) An employer, a majority of the employees in this state of an employer, or both, upon application, to pay the benefits afforded by a voluntary plan of unemployment compensation disability insurance. Notwithstanding the provisions of Section 10113, the policy may incorporate by reference any of the appropriate provisions of Part 2 (commencing with Section 2601) of Division 1 of the Unemployment Insurance Code and the authorized regulations of the Director of Employment Development.

(7) An employer, who shall be deemed the policyholder, providing benefits to any group of workers, dependents, or guests, limited by reference to specified hazards incident to activities or operations of the policyholder, for death or dismemberment, or for hospital, medical, surgical, or nursing expenses, resulting from accident. When the premium for the insurance is paid by the person insured, he or she may, upon request, obtain from the insurer in certificate form a copy of the policy.

(8) Any common carrier or any operator, owner, or lessor of a means of transportation, who shall be deemed the policyholder, providing benefits to any group of persons who may become lessees or passengers, limited by reference to their travel status on that common carrier or that means of transportation, for death or dismemberment, or for hospital, medical, surgical, or nursing expenses, resulting from accident. When the premium for the insurance is paid by the person insured, he or she may, upon request, obtain from the insurer in certificate form a copy of the policy.

(9) An entertainment production company, who shall be deemed the policyholder, providing benefits to any group of participants, volunteers, audience members, contestants, or workers for death or dismemberment, or for hospital, medical, surgical, or nursing expenses, resulting from accident while engaged in any activity or operation of the policyholder. When the premium for the insurance is paid by the person insured, he or she may, upon request, obtain from the insurer in certificate form a copy of the policy.

(b) A "blanket policy" is any disability policy of the nature herein described sold to any of the entities described in paragraphs (1) to (9), inclusive, of subdivision (a) that provides coverage for any group of persons within permitted categories defined in the policy. Policies referred to in paragraph (6) of subdivision (a) shall comply with the provisions of this section specifically referring thereto. Policies referred to in paragraphs (1) to (5), inclusive, or (7) to (9), inclusive, of subdivision (a) may provide that the cost of the insurance coverage shall be borne by either the policyholder, or the individuals insured or their parents or guardians, payable through the policyholder. In the absence of a policy provision excluding coverage for otherwise covered individuals who have not individually enrolled with the policyholder and undertaken to pay all or a specified portion of the premium allocable to the individual, the policy shall provide the described insurance for all who fall within the categories of covered individuals defined in the policy. The policy may, but is not required to, contain provisions requiring a minimum number of participating persons or a minimum percentage of participation before the policy is effective. In the absence of such a provision, coverage shall not be denied any individual otherwise eligible on those grounds.

(c) A policy described in paragraphs (1) to (5), inclusive, or (7) to (9), inclusive, of subdivision (a) shall not be issued until approved as to substance and form by the commissioner. The commissioner may, after notice and hearing, promulgate reasonable rules and regulations relating to the substance, form, and issuance of the policies that are necessary or desirable to preserve, insofar as applicable, standards of substance, form, and issuance comparable to the standards prescribed by this chapter that are applicable to other types of disability policies, and to further the purposes for which the policies are issued.

(d) A policy described in paragraph (6) of subdivision (a) shall not be issued until approved as to form by the commissioner. The commissioner may, after notice and hearing, promulgate reasonable rules and regulations relating to the form and issuance of the policies that do not affect the substance of the coverage, and that are necessary or desirable to preserve, insofar as applicable, standards of form and issuance comparable to the standards prescribed by this chapter that are applicable to other types of disability policies, and to further the purposes for which the policies are issued. Notwithstanding the provisions of Section 10113, the policy may incorporate by reference any of the appropriate provisions of Part 2 (commencing with Section 2601) of Division 1 of the Unemployment Insurance Code and the authorized regulations of the Director of Employment Development.

(e) A policy described in this section shall not constitute workers' compensation insurance, as defined in Section 109. A policy described in paragraphs (3), (5), (7), (8), or (9) of subdivision (a) shall not be marketed or sold as a substitute for health insurance coverage compliant with the requirements of the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152).

(f) (1) An insurer that intends to issue a policy of blanket insurance authorized by the amendments to this section pursuant to the act adding this subdivision, or authorized pursuant to section 10270.2.5, using a policy form previously approved by the commissioner, where the only new language in the policy is the specification of the policyholder, covered persons, or the hazards or activities insured, shall file that new language with the commissioner prior to issuance of the policy. Submissions of documents containing variable text or blanks shall include complete lists of the variable wording or accurate descriptions of the material to be inserted in lieu of the variable wording or in the blanks of these documents.

(2) A policy using the new language shall not be issued until either 30 days expires without notice from the commissioner after the new language is filed, or the commissioner gives his or her written approval prior to that time. If the commissioner at any time notifies the insurer, in writing and specifying the reasons for his or her opinion, that the filed new language does not comply with the requirements of law, the insurer shall not issue any policy containing that language.

(3) Nothing in this subdivision shall be construed to provide separate authority for the commissioner to reopen review of previously approved policy forms.

10270.2.5. (a) In addition to the permitted types of blanket insurance issued to entities described in Section 10270.2, the commissioner may, in his or her discretion, add other entities that may be eligible to purchase blanket insurance for any class of risks relating to benefits for death or dismemberment, or for hospital, medical, surgical, or nursing expenses, resulting from accident which may be properly eligible for blanket insurance.

(b) (1) The commissioner may issue a letter order, and shall post the letter order on the Internet Web site of the Department of Insurance, any time he or she exercises discretion pursuant to subdivision (a) to add other entities that may be eligible to purchase blanket insurance. These letter orders shall not be subject to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(2) The commissioner may withdraw a letter order issued pursuant to this section in the manner described in subdivision (f) of Section 10291.5. A proceeding under this subdivision shall not be subject to Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

(Added by Stats. 2012, Ch. 321, Sec. 3. (AB 2084) Effective January 1, 2013.)

10270.3. (a) A blanket disability policy of a type permitted under paragraph (2) or (5) of subdivision (a) of Section 10270.2 may include either a coordination of benefits policy provision or a nonduplication of benefits policy provision, at the option of the policyholder.

(b) The essential features of any policy under paragraph (2) or (5) of subdivision (a) of Section 10270.2 shall be disclosed to the insured, or the parent or legal guardian of the insured, prior to enrollment in that policy. All disclosures shall state whether or not the benefits payable under the blanket insurance policy are subject to reduction, to the extent provided in the policy, if an individual insured thereunder is entitled to benefits, whether on an indemnity basis or on a provision-of-service basis, for hospital, medical, dental, or surgical expenses under any other valid and collectible individual, group, or blanket insurance policy or contract, hospital or medical service program, or group-practice prepayment plan, except for automobile medical payments insurance.

(c) The disclosure material shall be submitted to the commissioner for review with the blanket insurance policy.

(Amended by Stats. 2012, Ch. 321, Sec. 4. (AB 2084) Effective January 1, 2013.)

10270.4. Any disability insurer may issue policies of group disability insurance and family expense disability insurance as defined in this article but shall not issue any form of policy of group disability insurance, or family expense disability insurance except as prescribed in this article and except as provided in Article 6.7 of Chapter 1 of Part 2 of Division 1. Provided, however, that during the calendar years of 1952 to 1956, inclusive, a policy of family expense disability insurance as defined in Section 10270.7 may either (1) contain the provisions required by Section 10270.8 and those promulgated by the commissioner pursuant to Sections 10270.9 and 10270.93 and be subject to this article and to Section 10291.5 or (2) be filed and approved under Article 2 of this chapter and be subject to such article and to Articles 3a, 4a and 5a of this chapter and contain the provision required by Section 10270.8(b). On and after January 1, 1957 the provisions of this article shall no longer relate to such policies except Section 10270.7 and subdivision (b) of Section 10270.8 and all of such policies shall be subject to the provisions set forth in alternative (2) above, except that such policies need not comply with subsection (c) of Section 10320 if they comply with Section 10270.7.

(Amended by Stats. 1963, Ch. 2055.)

10270.5. Group disability insurance is that form of disability insurance which conforms to all of the following conditions:

(a) Written under a master policy, issued to any of the following:

(1) The federal or state government, any federal or state agency, political subdivision or district, any public, governmental, or municipal corporation, any unit, agency, or department thereof, any corporation, copartnership or individual employer, or to the trustee of any association of employers, offering insurance to all the employees of the employer or of the employer members of the association or to all of any class or classes thereof determined by conditions pertaining to employment and covering not less than two such employees or those employees together with their dependents or spouses for amounts of insurance based upon some plan which will preclude individual selection by the employee as to the amount of his or her insurance coverage thereunder.

(2) A principal eligible to have issued to him or her a policy of group life insurance under the provisions of Section 10203.7 and insuring not less than two agents as defined in that section and eligible thereunder to be insured, or those agents together with their dependents or spouses.

(3) Any association having a constitution and bylaws and formed and continuously maintained in good faith for purposes other than that of obtaining insurance, offering insurance to all the eligible members, or class of members, of the association and covering not less than two such members or those members together with their dependents or spouses and not less than 25 percent of all eligible members, or class of members, for amounts of insurance based upon some plan which will preclude

individual selection by the member as to the amount of his or her insurance coverage thereunder. If the master policy is to be issued to cover members of labor unions, it may be issued to more than one such union.

(4) An association or a trust, or the trustees of a fund established, created, or maintained for the benefit of members of one or more associations. The association or associations shall have at the outset a minimum membership of 100 persons, and shall be organized and maintained in good faith for purposes other than that of obtaining insurance. The association or associations shall have been in active existence for at least two years, and shall have a constitution and bylaws which require regular meetings not less than annually to further purposes of the members. The members shall have voting privileges and representation on the governing board or boards and committees. The policy shall be subject to the following requirements:

(A) The policy may insure members of the association or associations, and employees thereof.

(B) The premium for the policy shall be paid from funds contributed by the association or associations, or by members, or by both, or from funds contributed by the covered persons, or from both the covered persons and the association.

(C) A policy on which no part of the premium is to be derived from funds contributed by the covered persons specifically for the insurance shall insure all eligible persons, except those who, in writing, reject the coverage.

(5) Any trustees eligible to have issued to them a policy of group life insurance under the provisions of Section 10202.8 and insuring not less than two employees or members eligible thereunder to be insured or those employees or members together with their dependents or spouses.

(6) A school district or districts, the governing board of any school district or districts, a private or parochial school or schools, or the governing board or person in charge of the operation of any private or parochial school or schools, insuring not less than 50 pupils of the school or district and providing benefits to pupils or persons responsible for their support for death or dismemberment resulting from accident or for hospital, medical and surgical expenses resulting from accident to those pupils while they are in or on buildings or premises of the schools or districts during the time the pupils are required to be therein or thereon by reason of their attendance upon a college or a regular day school or any regular day school of a school district or districts or while being transported by the school or schools or district or districts to and from school or other place of instruction or while at any other place as an incident to school-sponsored activities and while being transported to, from and between these places.

(b) Transmission or collection of all premiums or premium contributions shall be performed by the policyholder, except where the policy specifies the persons other than the policyholder by whom the transmission or collection shall be made, and in one of the following situations:

(1) If the policy covers the employees of more than one employer, the insurer may collect premium contributions from individual employers whose employees are insured or may assist the policyholder in making these collections. If the employees of more than 100 such employers are covered under that policy, it shall state as a separate part of the premium to be charged for the policy the amount to be charged by the insurer for the collection.

(2) If the policy covers a group of governmental employees and the governmental unit paying those employees will not transmit their premium contribution after payroll deduction, the insurer may collect from the individual employees. If more than 100 of these employees are covered under that policy, it shall state as a separate part of the premium to be charged for the policy the amount to be charged by the insurer for the collection.

(3) If individual members of the group make payment of their share of the premium contribution to the insurer with or without billing or solicitation by the insurer during a period of temporary absence from active work of not exceeding 90 days, the payment may be received without the necessity of any separately stated charge by the insurer.

(4) If the policy covers the members of an association, the insurer may collect premium contributions from individual members or may assist the policyholder in making these collections. If more than 100 such members are covered under that policy, it shall state as a part of the premium to be charged for the policy the amount to be charged by the insurer for the collection.

(c) There is issued and delivered in accordance with the policy provision required by subdivision (b) of Section 10270.6 an individual certificate setting forth the benefits and the exceptions under, and referring to, the master policy under which the certificate is issued.

Those certificates are not subject to the provisions of this chapter relating to the master policy, but the forms thereof shall be submitted to the commissioner for his or her approval and shall not be issued without approval of the forms in the manner provided in the case of the master policy.

(Amended by Stats. 2007, Ch. 78, Sec. 4. Effective January 1, 2008.)

10270.505. Another permitted form of group disability insurance is that which conforms to all of the following conditions.

(1) Covering debtors who are or become obligated to repay an indebtedness in substantially equal installments, or to repay a portion of an indebtedness in substantially equal installments over a year or more and repay a final balance in any amount on a

date certain thereafter, to one creditor, as "creditor" is defined in subdivision (3) of Section 779.2.

(2) The group numbers not less than 10 new entrants yearly.

(3) The amounts insured on any one debtor do not exceed those permitted by Section 779.4.

(4) The policy is issued upon application of and made payable to the creditor or his successor in interest and such alternate beneficiaries as are required by Article 5.9 (commencing with Section 779.1) of Chapter 1 of Part 2 of Division 1, and the premiums are paid by or through the creditor.

A policy issued under this section shall conform to all applicable provisions of this code.

(Amended by Stats. 1969, Ch. 422.)

10270.507. Except as provided in Section 10195 with respect to regulation of group Medicare supplemental insurance, and provisions of law regulating group long-term care insurance, no certificate of group disability insurance advertised or marketed to persons in this state shall be issued or delivered on or after January 1, 1989, to any person 55 years of age or older in this state pursuant to a group master insurance policy issued or delivered in another state unless the certificate and master policy have been filed with, and approved by, the commissioner.

This section does not apply to policies issued to one or more employers or labor organizations, or to the trustees of funds established by one or more employers or labor organizations, or combination thereof, for employees or former employees, or combination thereof, or for members or former members, or combination thereof, of the labor organization.

The commissioner shall adopt regulations necessary to interpret and implement this section.

(Added by Stats. 1988, Ch. 1322, Sec. 1.)

10270.51. The state and any political subdivisions thereof and any municipality, may provide for the type of insurance set forth in Section 10270.5 of this code the same as any private employer and may contribute to a fund established under such section the same as any private employer.

A county may include as persons eligible under its master policy issued pursuant to Section 10270.5, employees of a district located wholly or partially within the county. Such inclusion of district employees is subject to Section 53200.4 of the Government Code.

(Amended by Stats. 1968, Ch. 935.)

10270.55. (a) With respect to a policy issued to a corporation, copartnership or individual employer eligible for group insurance pursuant to Section 10270.5, the term "employees" may be deemed to include the officers, managers and employees of subsidiary or affiliated corporations, and the individual proprietors, partners and employees of affiliated individuals and firms, when the business of such subsidiary or affiliated corporations, firms or individuals is controlled by the policyholder through stock ownership, contract or otherwise, or when the policyholder is controlled by affiliated corporations, firms or individuals through stock ownership, contract or otherwise.

(b) With respect to a policy issued to a copartnership or individual employer pursuant to Section 10270.5, the term "employees" may be deemed to include the individual proprietor or partners of the policyholder.

(c) With respect to a policy issued to a trust pursuant to subdivisions (1) or (4) of subsection (a) of Section 10270.5 the term "employees" may be deemed to include (1) the individual proprietors and partners of any employers which are individual proprietors or partnerships, (2) the employees of an association and (3) the trustee, or trustees, or the employees of the trustee, or trustees, or both, if their duties are principally connected with such trusteeship.

(d) With respect to a policy issued to an association pursuant to subdivision (3) of subsection (a) of Section 10270.5 the term "members" may be deemed to include the employees of the association.

(e) Nothing contained herein shall permit a director of a corporate employer to become insured under a group policy unless such person is otherwise eligible as a bona fide employee of the corporation by performing services other than the usual duties of a director.

(f) Nothing contained herein shall permit an individual proprietor or partner to become insured under a group policy unless he is actively engaged in and devotes a substantial part of his time to the conduct of the business of the proprietor or partnership.

(g) Nothing contained herein shall permit any employee to become insured under a group policy unless he is an officer, manager, or employee for compensation of the employer to whom a group policy is issued, or of one or more of the individuals, firms, or corporations specified in subdivision (a), or of the association or trustee or trustees specified in subdivision (c), or of the association specified in subdivision (d).

(h) Officers, managers, and employees of a public agency who receive no compensation may be insured under a group policy purchased pursuant to the provisions of Article 1 (commencing with Section 53200) of Chapter 2, Part 1, Division 2, Title 5 of the

Government Code.

(Amended by Stats. 1972, Ch. 420.)

10270.57. Another form of group disability insurance is that form of disability insurance conforming to the following conditions:

(a) Written under a master policy issued to the trustee of any self-employed individuals, whether or not they have any employees, all of whom have contracts with the same publisher of a newspaper, for the performance of services for such publisher as independent contractors, offering insurance to such self-employed individuals and to all the employees of any such persons and covering not less than 10 such self-employed individuals and their employees or such individuals and their employees together with their dependents or spouses for amounts of insurance based upon some plan which will preclude individual selection by the eligible person as to the amount of his insurance coverage thereunder;

(b) For delivery to each person insured thereunder, other than dependents or spouses of an insured employee or person, there is issued to the holder of the master policy by the insurer an individual certificate setting forth the benefits and the exceptions under, and referring to, the master policy under which the certificate is issued.

Such certificates are not subject to the provisions of this chapter relating to the master policy, but the forms thereof shall be submitted to the commissioner for his approval and shall not be issued without such approval of such forms in the manner provided in the case of the master policy.

(Added by Stats. 1963, Ch. 1528.)

10270.6. Every group disability master policy shall contain the following provisions:

(a) A provision that the policy, the application of the policyholder, and the individual applications, if any, of the individuals insured shall constitute the entire contract between the parties, and that all statements made by the policyholder, or by the individuals insured shall, in the absence of fraud, be deemed representations and not warranties, and that no such statement shall be used in defense to a claim under the policy, unless it is contained in a written application;

(b) A provision that the insurer will issue to the policyholder for delivery to the individuals insured under such policy, an individual certificate setting forth a statement as to the insurance protection to which he or she is entitled and to whom payable;

(c) A provision that to the group or class thereof originally insured shall be added from time to time all new employees, members, or pupils of the policyholder eligible to and applying for insurance in such group or class;

(d) A statement that such policy is not in lieu of and does not affect any requirement for coverage by workers' compensation insurance.

(Amended by Stats. 2018, Ch. 231, Sec. 16. (AB 2045) Effective January 1, 2019.)

10270.63. An individual certificate shall be individualized, except that in the case of an individual certificate under a group policy which requires no regular contribution toward the payment of the premium to be made by the individuals covered thereunder, such individual certificate need not be individualized if it is in a form setting forth a clear statement of the conditions of eligibility from which the person covered can determine the circumstances under which he is insured under the master policy.

An individual certificate shall be deemed to be "individualized," within the meaning of this section, if it contains either the name of the person covered or some other means of identifying to the individual covered that it is his individual certificate.

(Added by Stats. 1955, Ch. 1729.)

10270.65. If hereafter any dividend is paid or any premium refunded under any policy of group disability insurance heretofore or hereafter issued, the excess, if any, of the aggregate dividends or premium refunds under such policy over the aggregate expenditures for insurance under such policy made from funds contributed by the policyholder, or by an employer of such insured persons or by union or association to which insured persons belong, including expenditures made in connection with the administration of such policy, shall be applied by the policyholder for the benefit of such insured employees generally or their dependents or insured members generally or their dependents. For the purpose of this section and at the option of the policyholder, "policy" may include all group life and disability insurance policies of the policyholder.

(Added by Stats. 1953, Ch. 1746.)

10270.7. Family expense disability insurance is that form of disability insurance insuring more than one person and issued to the head of a family or his spouse indemnifying him, or his spouse, or both, against loss due to disability of one or more persons dependent at the time of issuance upon him, or his spouse, or both, and may include indemnification on account of his own disability and disability of his spouse whether or not either is dependent on the other.

Where such a policy provides for payment for expenses incurred, expenses incurred by or upon behalf of any person covered by the policy shall be deemed incurred by the person to whom or at whose direction benefits are payable under the policy.

No question as to whether or not any person is the head of the family or his spouse, or is a child or dependent of either shall relieve the insurer of any liability it otherwise would have under the policy.

Where such a policy indemnifies a spouse alone or a spouse and the head of the family, references in the policy to the head of the family shall be deemed to refer to or include the spouse.

(Amended by Stats. 1951, Ch. 887.)

10270.8. Family expense disability policies shall also contain the following provisions:

(a) A provision that the policy and the application, if any, of the head of the family shall constitute the entire contract between the parties, and that all statements made by the head of the family shall, in the absence of fraud, be deemed representations and not warranties, and that no statement shall be used in defense to a claim under the policy, unless it is contained in a written application;

(b) A provision that to the family originally insured may be added from time to time all new members of the family eligible for insurance in such family; and that the head of the family shall give the insurer notice of the addition to the family of any person eligible for coverage under the policy.

(Amended by Stats. 1955, Ch. 1596.)

10270.9. No group disability policy shall be issued or delivered in this state nor, except as otherwise provided in Sections 10270.91 and 10270.98, shall an insurer provide or agree to provide group disability coverage until a copy of the form of the policy is filed with the commissioner and approved by him in accordance with Article 2 of this chapter as meeting in substance the reasonably applicable provisions and requirements of either Articles 3, 4 and 5 of this chapter or Articles 3a, 4a and 5a of this chapter; provided, however, that the insurer may, at its option, substitute for one or more of such provisions of Articles 4a and 5a corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the policyholder, the certificate holder or the beneficiary. On and after January 1, 1957, no group disability policy shall be issued or delivered in this state unless the form thereof has been approved, as required by this section, as meeting in substance the provisions and requirements of Articles 3a, 4a and 5a of this chapter which are reasonably applicable; provided, however, that the insurer may, at its option, substitute for one or more of such provisions of Articles 4a and 5a corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the policyholder, the certificate holder or the beneficiary.

Except as provided by Section 10314, no group disability policy shall be issued or delivered to any person in this state nor shall any endorsement for any such policy be issued which contains any provision contradictory, in whole or in part, of any of the provisions promulgated by the commissioner as being required or optional or alternative provisions to be incorporated into such policy in accordance with the rules promulgated by him for their use.

(Amended by Stats. 1967, Ch. 1548.)

10270.91. An insurer is permitted to provide group disability coverage prior to the approval of the form of the policy if all of the conditions of (a) are met prior thereto and if thereafter it acts as required by (b).

(a) The conditions precedent are:

(1) The group is one eligible for coverage pursuant to the provisions of this article; and

(2) An executed memorandum of insurance has been or is concurrently delivered to the entity which is to become the policyholder containing a provision that unless a policy the form of which has been approved by the commissioner and embodying the coverage has been issued and delivered to the policyholder within 90 days after the date on which the coverage is provided or agreed to be provided, the coverage provided pursuant to such memorandum terminates 120 days after such date, and containing a specification in either complete or summary form of:

(i) The class or classes of employees eligible for coverage;

(ii) The benefits to be provided; and

(iii) The exceptions and reductions to such benefits, if any.

(b) An insurer providing coverage pursuant to this section shall:

(1) Within 60 days after the date on which the coverage is provided or agreed to be provided submit to the commissioner for approval a policy form drafted to provide the coverage provided by such memorandum and in a good faith attempt to meet all requirements of law;

(2) Make such revisions in the policy submitted as the commissioner may lawfully require; and

(3) Terminate such coverage in accordance with the provisions of (a) (2) above if approval of such policy is not secured within the time specified therein.

Upon written request from the insurer filed within 50 days after the date on which the coverage is provided or agreed to be provided and upon proof satisfactory to him that the insurer is acting with due diligence and that hardship will result unless an extension is granted, the commissioner may extend the time set forth in (b) (1) hereof for a period of not to exceed 30 days. Upon such extension, the insurer with the consent of the policyholder may amend the memorandum of insurance referred to in (a) (2) hereof to extend the time within which the policy must be issued and delivered to the policyholder to 30 days after the date to which the commissioner has extended the time within which a policy form must be submitted to him for approval and to extend the date for termination of coverage to 30 days thereafter.

Any policy submitted to the commissioner with a letter from the insurer stating that coverage has been provided in accordance with this section shall be automatically approved unless the commissioner disapproves the same within 30 days of the date of its submission to him.

(Added by Stats. 1953, Ch. 624.)

10270.92. The commissioner may suspend or revoke the permission granted any insurer in Section 10270.91 if, after notice and hearing in accordance with Chapter 5 of Part 1 of Division 3 of Title 2 of the Government Code, he finds that the insurer has:

- (a) Misrepresented the conditional nature of the coverage;
- (b) Neglected or refused either to cancel or otherwise terminate such coverage within the time required by such section;
- (c) Delivered any such memorandum which did not comply with subsection (a) (2) of Section 10270.91;
- (d) Shown a lack of diligence in making revisions in the policy necessary to obtain its approval by the commissioner;
- (e) Failed so often in so many important respects in drafting any such policy to conform to the applicable requirements of the Insurance Code that a conclusion of lack of good faith or competency in drafting is reasonably justified;
- (f) Circulated announcements of coverage to individuals insured which failed to advise them of the conditional nature of the coverage; or
- (g) In any other manner so negligently or carelessly handled the effecting of insurance under Section 10270.91 or the administration thereof that the policyholder or the persons insured have been misled or exposed to the danger of loss.

(Added by Stats. 1953, Ch. 624.)

10270.93. No family expense disability policy shall be issued or delivered in this State unless a copy of the form thereof is filed with the commissioner and approved by him in accordance with Article 2 of this chapter as meeting in substance either the provisions and requirements of Articles 3, 4 and 5 of this chapter which are reasonably applicable, or the provisions and requirements of Articles 3a, 4a and 5a of this chapter which are reasonably applicable; provided, however, that the insurer may, at its option, substitute for one or more of such provisions of Articles 4a and 5a corresponding provisions of different wording approved by the commissioner which are in each instance not less favorable in any respect to the insured or the beneficiary.

Except as provided by Section 10314, no family expense disability policy shall be issued or delivered to any person in this State nor shall any endorsement for any such policy be issued which contains any provision contradictory, in whole or in part, of any of the provisions promulgated by the commissioner as being required or optional or alternative provisions to be incorporated into such policy, except a policy or endorsement which has been approved by the commissioner under Article 2 of this chapter as meeting the applicable requirements of Articles 2, 3a, 4a and 5a of this chapter and as containing the provisions or substitute provisions as required by Articles 4a and 5a of this chapter modified in such manner as to make the provisions consistent with family expense coverage and the coverage provided in the policy and endorsement, if any. On and after January 1, 1957, no family expense disability policy shall be delivered or issued for delivery to any person in this State unless it complies with Articles 2, 3a, 4a and 5a of this chapter.

(Added by Stats. 1953, Ch. 624.)

10270.94. The commissioner shall promulgate forms of provisions which incorporate in substance the applicable provisions set forth in Articles 4 (commencing with Section 10329), 4a (commencing with Section 10350), 5 (commencing with Section 10359), and 5a (commencing with Section 10369.1), and shall promulgate rules governing the use of those provisions, incorporating the substance, insofar as applicable, of the corresponding rules contained in this chapter for the use of the provisions set forth in Articles 4, 4a, 5, and 5a. However, as of January 1, 1957, the promulgation of provisions and rules governing their use incorporating in substance the applicable provisions of Articles 3 (commencing with Section 10309), 4 (commencing with Section 10329), and 5 (commencing with Section 10359) shall cease to be effective, and on and after January 1, 1957, only the promulgation of provisions and rules governing their use incorporating in substance the applicable provisions of Articles 3a (commencing with Section 10320), 4a (commencing with Section 10350), and 5a (commencing with Section 10369.1) shall be effective. The commissioner may from time

to time thereafter change any such provisions or rules governing their use previously promulgated by him or her. The promulgation of any such provisions or rules governing their use and of any changes or amendments thereof shall be in accordance with the procedure provided in Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(Amended by Stats. 1985, Ch. 106, Sec. 96.)

10270.95. Without affecting the applicability or degree of applicability of other sections of this chapter, it is hereby specified that the provisions of Sections 10321, 10325, 10401, of subdivisions (a), (c), (e), (h) and (i) of Section 10320, of subdivision (a) of Section 10290, of paragraphs (2), (3), (4), (5), (6), (7), (8), (9), (10), (11) and (12) of subdivision (b) and subdivisions (e), (f), (g), (h), (i), and (k) of Section 10291.5 and of Section 10291.6, shall not apply to group disability insurance. The provisions of Section 10401 shall not apply to family expense disability insurance; provided, there is no discrimination between families of the same class.

(Amended by Stats. 1995, Ch. 94, Sec. 1. Effective January 1, 1996.)

10270.97. Selected group disability insurance is that form of disability insurance conforming to the following conditions:

(a) Written under individual policies

(1) Issued to not less than three employees of the federal or state government, or of any federal or state agency, political subdivision or district, or of any public, governmental, or municipal corporation, or of any unit, agency, or department thereof, or of any corporation, copartnership or individual employer; or

(2) Issued to not less than three members of any association, which shall have been in existence for at least two years, having a constitution and bylaws and formed and continuously maintained in good faith for purposes other than that of obtaining insurance; and

(3) For amounts of insurance based upon individual selection by the insured employee or member, as the case may be.

(b) Notwithstanding the provisions of Section 10401 insurers may be permitted to file (for use in connection with selected group disability insurance), rate schedules that reflect a differential from the rates charged for identical policies issued on the individual basis, provided they do not make or permit any discrimination between selected groups.

(Amended by Stats. 1987, Ch. 443, Sec. 2.)

10270.98. Group disability policies may provide, among other things, that the benefits payable thereunder are subject to reduction if the individual insured has any other coverage (other than individual policies or contracts) providing hospital, surgical or medical benefits, whether on an indemnity basis or a provision of service basis, resulting in such insured being eligible for more than 100 percent of the covered expenses.

Except as permitted by this section and by Section 10323, 10369.5, 10369.6, or 11515.5, and except in the case of group practice prepayment plan contracts which do not provide for coordination of benefits, to the extent they provide for a reduction of benefits on account of other coverage with respect to emergency services that are not obtained from providers that contract with the plan, no group or individual disability insurance policy or service contract issued by nonprofit hospital service plans operating under Chapter 11A (commencing with Section 11491) of Part 2 of Division 2 shall limit payment of benefits by reason of the existence of other insurance or service coverage.

The policy provisions authorized by this section shall contain a provision that payments of funds may be made directly between insurers and other providers of benefits. Such policy provisions shall also contain a provision that if benefits are provided in the form of services rather than cash payments the reasonable cash value of each service rendered shall be deemed to be both an allowable expense and a benefit paid. The reasonable cash value of any contractual benefit provided to the insured in the form of service rather than cash payment by or through any hospital service organization or medical service organization or group-practice prepayment plan shall be deemed an expense incurred by the insured for such service, whether or not actually incurred, and the liability of the insurer shall be the same as if the insured had not been entitled to any such service benefit, unless the policy contains a provision authorized by Section 10323, 10369.5 or 10369.6 in the case of an individual disability policy, or by this section, in the case of a group disability policy.

This section shall not be construed to require that benefits payable under group disability policies be subject to reduction by the benefit amounts payable under Chapter 3 (commencing with Section 2800) of Part 2 of Division 1 of the Unemployment Insurance Code.

The provisions of this section, and all regulations adopted pursuant thereto pertaining to coordination of benefits with other group disability benefits, shall apply to all employers, labor-management trustee plans, union welfare plans (including those established in conformity with 29 U.S.C. Sec. 186), employer organization plans or employee benefit organization plans, health care service plan contracts, pursuant to regulations adopted by the Director of the Department of Managed Health Care which shall be uniform with those issued under this section for those plans that elect to coordinate benefits, group practice, individual practice, any other

prepayment coverage for medical or dental care or treatment, and administrators, within the meaning of Section 1759 not otherwise subject to the provisions of this section whenever such plan, contract or practice provides or administers hospital, surgical, medical or dental benefits to employees or agents who are also covered under one or more additional group disability policies which are subject to this section or health care service plans.

(Amended by Stats. 2000, Ch. 857, Sec. 66. Effective January 1, 2001.)

10270.99. The term "individual policies or contracts," as used in the first paragraph of Section 10270.98, does not include selected group disability policies or contracts, unless those policies or contracts are noncancelable or guaranteed renewable and solely provide hospital confinement indemnity or specified disease coverage.

(Amended by Stats. 1987, Ch. 336, Sec. 1.)

10271. (a) Except as set forth in this section and in Sections 10271.1, 10292, and 10295 to 10295.19, inclusive, this chapter does not apply to, or in any way affect, provisions in life insurance, endowment, or annuity contracts, or contracts supplemental thereto, that provide additional benefits in case of death or dismemberment or loss of sight by accident, or that operate to safeguard those contracts against lapse, as described in subdivision (a) of Section 10271.1, or give a special surrender benefit, as defined in subdivision (b) of Section 10271.1, a terminal illness benefit, as defined in subdivision (d) of Section 10271.1, or an accelerated death benefit, as defined in Article 2.1 (commencing with Section 10295), in the event that the owner, insured, or annuitant, as applicable, meets the benefit triggers specified in the life insurance or annuity contract or supplemental contract.

(b) For the purposes of this section, "supplemental benefit" means a rider to or provision in a life insurance policy, certificate, or annuity contract that provides a benefit as set forth in subdivision (a).

(c) A supplemental benefit described in subdivision (a) shall contain all of the following provisions. However, an insurer, at its option, may substitute for one or more of the provisions a corresponding provision of different wording approved by the commissioner that is not less favorable in any respect to the owner, insured, or annuitant, as applicable. The required provisions shall be preceded individually by the appropriate caption, or, at the option of the insurer, by the appropriate individual or group captions or subcaptions as the commissioner may approve.

(1) A life insurance policy or annuity contract that contains a supplemental benefit shall provide that the contract, supplemental contract, and papers attached thereto by the insurer, including the application if attached, constitute the entire insurance or annuity contract and shall also provide that an agent does not have the authority to change the contract or to waive its provisions. This provision shall be preceded individually by a caption stating "ENTIRE CONTRACT; CHANGES:" or other appropriate caption as the commissioner may approve.

(2) The supplemental benefit shall provide that reinstatement of the supplemental benefit shall be on the same or more favorable terms as reinstatement of the underlying life insurance policy or annuity contract. Following reinstatement, the insured and insurer shall have the same rights under reinstatement as they had under the supplemental benefit immediately before the due date of the defaulted premium, subject to the provisions endorsed in the rider or endorsement or attached to the rider or endorsement in connection with the reinstatement. This reinstatement provision shall be preceded individually by a caption stating "REINSTATEMENT:" or other appropriate caption as the commissioner may approve.

(3) A supplemental benefit subject to underwriting shall include an incontestability statement that provides that the insurer shall not contest the supplemental benefit after it has been in force during the lifetime of the insured for two years from its date of issue, and that the supplemental benefit may only be contested based on a statement made in the application for the supplemental benefit, if the statement is attached to the contract and if the statement was material to the risk accepted or the hazard assumed by the insurer. This provision shall be preceded individually by a caption stating "INCONTESTABILITY:" or other appropriate caption as the commissioner may approve.

(4) A supplemental benefit shall contain the provision in subparagraph (A), except that an accelerated death benefit as defined in Article 2.1 (commencing with Section 10295) shall contain the provision in subparagraph (B).

(A) The supplemental benefit shall provide either that the insurer may accept written notice of claim at any time or that the insurer may require that written notice of claim be submitted by a due date that is no less than 20 days after an occurrence covered by the supplemental benefit, or commencement of a loss covered by the supplemental benefit, or as soon after the due date as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary, as applicable, to the insurer at the insurer's address or telephone number, or to an authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. This provision shall be preceded individually by a caption stating "NOTICE OF CLAIM:" or other appropriate caption as the commissioner may approve.

(B) The accelerated death benefit shall provide either that the insured may give notice of claim at any time or that the insured shall give notice of claim by a due date that is at least 20 days after the insured receives documentation that establishes the occurrence of a qualifying event, or as soon after the due date as is reasonably possible. Notice given by or on behalf of the insured or the beneficiary, as applicable, to the insurer at the insurer's address or telephone number, or to an authorized agent of the insurer, with information sufficient to identify the insured, shall be deemed notice to the insurer. This provision shall be preceded individually by a caption stating "NOTICE OF CLAIM:" or other appropriate caption as the commissioner may approve.

(5) A supplemental benefit shall contain the provision in subparagraph (A), except that an accelerated death benefit as defined in Article 2.1 (commencing with Section 10295) shall contain the provision in subparagraph (B).

(A) The supplemental benefit shall provide that the insurer, upon receipt of a notice of claim, shall furnish to the claimant those forms as are usually furnished by it for filing a proof of occurrence or a proof of loss. If the forms are not furnished within 15 days after giving notice, the claimant shall be deemed to have complied with the requirements of the supplemental benefit as to proof of occurrence or proof of loss upon submitting, within the time fixed by the supplemental benefit for filing proof of occurrence or proof of loss, written proof covering the character and the extent of the occurrence or loss. This provision shall be preceded individually by a caption stating "CLAIM FORMS:" or other appropriate caption as the commissioner may approve.

(B) The accelerated death benefit shall provide that the insurer, upon receipt of a notice of claim, shall furnish to the claimant any forms required for filing proof of loss. If the forms are not furnished within 15 days after notice of claim is given to the insurer, the claimant shall be deemed to have provided proof of loss upon sending, within the time fixed by the supplemental benefit for filing proof of loss, documentation that establishes the occurrence of a qualifying event. This provision shall be preceded individually by a caption stating "CLAIM FORMS:" or other appropriate caption as the commissioner may approve.

(6) A supplemental benefit shall contain the provision in subparagraph (A), except that an accelerated death benefit as defined in Article 2.1 (commencing with Section 10295) shall contain the provision in subparagraph (B).

(A) The supplemental benefit shall provide that the insurer may require, in the case of a claim for which the supplemental benefit provides a periodic payment contingent upon continuing occurrence or loss, that the insured provide written proof of occurrence or proof of loss no less than 90 days after the termination of the period for which the insurer is liable, and, in the case of claim for any other occurrence or loss, that the insured provide written proof of occurrence or proof of loss within 90 days after the date of the occurrence or loss. Failure to furnish proof within the time required shall not invalidate or reduce the claim if it was not reasonably possible to give proof within the time, provided proof is furnished as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required. This provision shall be preceded individually by a caption stating "PROOF OF LOSS:" or other appropriate caption as the commissioner may approve.

(B) The accelerated death benefit shall provide that the insured shall send completed claim forms and documentation that establishes the occurrence of a qualifying event within 90 days of receiving that documentation. Failure to send proof within the time required shall not invalidate or reduce the claim as long as proof is sent as soon as reasonably possible and, except in the absence of legal capacity, no later than one year from the time proof is otherwise required. This provision shall be preceded individually by a caption stating "PROOF OF LOSS:" or other appropriate caption as the commissioner may approve.

(7) The supplemental benefit shall provide that the insurer, at its own expense, shall have the right and opportunity to examine the person of the insured when and as often as the insurer may reasonably require during the pendency of a claim and to make an autopsy in case of death where it is not forbidden by law. This provision shall be preceded individually by a caption stating "PHYSICAL EXAMINATIONS:" or other appropriate caption as the commissioner may approve.

(d) The commissioner shall not approve a contract or supplemental contract for issuance or delivery in this state if the commissioner finds that the contract or supplemental contract does any of the following:

(1) Contains a provision, label, description of its contents, title, heading, backing, or other indication of its provisions that is unintelligible, uncertain, ambiguous, or abstruse, or likely to mislead a person to whom the supplemental benefit is offered, delivered, or issued.

(2) Constitutes fraud, unfair trade practices, or insurance economically unsound to the owner, insured, or annuitant, as applicable.

(3) Contains actuarial information that is materially incomplete, incorrect, or inadequate.

(e) A supplemental benefit described in subdivision (a) shall not contain a title, description, or any other indication that would describe or imply that the supplemental benefit provides long-term care coverage.

(f) Commencing two years from the date of the issuance of the supplemental benefit, no claim for loss incurred or disability, as defined by the supplemental benefit, may be reduced or denied on the grounds that a disease or physical condition not excluded

from coverage by name or specific description effective on the date of loss had existed before the effective date on the coverage of the supplemental benefit.

(g) With regard to supplemental benefits set forth in subdivision (a), the supplemental benefit shall specify any applicable exclusions, which shall be limited to the following:

- (1) Condition or loss caused or substantially contributed to by any attempt at suicide or intentionally self-inflicted injury, while sane or insane.
- (2) Condition or loss caused or substantially contributed to by war or an act of war, as defined in the exclusion provisions of the contract.
- (3) Condition or loss caused or substantially contributed to by active participation in a riot, insurrection, or terrorist activity.
- (4) Condition or loss caused or substantially contributed to by committing or attempting to commit a felony.
- (5) Condition or loss caused or substantially contributed to by voluntary intake of either:
 - (A) A drug, unless prescribed or administered by a physician and taken in accordance with the physician's instructions.
 - (B) Poison, gas, or fumes, unless they are the direct result of an occupational accident.
- (6) Condition or loss in consequence of the insured being intoxicated, as defined by the jurisdiction where the condition or loss occurred.
- (7) Condition or loss caused or substantially contributed to by engaging in an illegal occupation.
- (8) Condition or loss caused or substantially contributed to by engaging in aviation, other than as a fare-paying passenger.

(h) If the commissioner notifies the insurer, in writing, that the filed form or actuarial information does not comply with the law and specifies the reasons for the commissioner's opinion, it is unlawful for an insurer to issue a policy in that form.

(Amended by Stats. 2021, Ch. 627, Sec. 13. (AB 1511) Effective January 1, 2022.)

10271.1. (a) (1) Supplemental benefits that operate to safeguard life insurance contracts against lapse are defined as a waiver of premium benefit or a waiver of monthly deduction benefit, as applicable, in which the insurer waives the premium or monthly deduction for a life insurance contract when the insured becomes totally disabled, as defined by the supplemental benefit, and where the waiver continues until the end of the insured's disability, or for the period specified by the supplemental benefit, consistent with paragraph (5).

(2) For purposes of this subdivision, total disability shall not be less favorable to the insured than the following:

(A) During the first 24 months of total disability, the insured is unable to perform with reasonable continuity the substantial and material duties of their job due to sickness or bodily injury.

(B) After the first 24 months of total disability, the insured, due to sickness or bodily injury, is unable to engage with reasonable continuity in any other job in which they could reasonably be expected to perform satisfactorily in light of their age, education, training, experience, station in life, or physical and mental capacity.

(3) The definition of total disability may also include presumptive total disability, such as the insured's total and permanent loss of sight of both eyes, hearing of both ears, speech, the use of both hands, both feet, or one hand and one foot.

(4) The insurer may require total disability to continue for an uninterrupted period of time specified by the supplemental benefit, or the insurer may allow separate periods of disability to be combined.

(5) The waiver of premium or monthly deduction benefit shall continue for the period specified by the supplemental benefit, but shall not be less favorable to the insured than the following:

(A) If the insured's total disability begins before the insured attains 60 years of age, the insurer shall waive all premiums or monthly deductions due for the period that the insured continues to be totally disabled, except as follows:

(i) For group life insurance policies, if the insured's total disability begins before the insured attains 60 years of age, the insurer shall waive all premiums or monthly deductions due for the period of total disability up to 65 years of age. This subdivision does not preclude the insurer from extending a supplemental benefit for longer periods.

(ii) When a renewal is offered for a group life insurance policy that was issued prior to January 1, 2017, and contains a supplemental benefit described in this subparagraph, the insurer shall offer to renew the policy with a continuation of the in-force supplemental benefit, and may concurrently offer the group policyholder the option to change the supplemental benefit as described in clause (i).

(B) If the insured's total disability begins after the age specified in subparagraph (A), the insurer shall waive all premiums or monthly deductions due for the period that the insured continues to be totally disabled up to 65 years of age, except as follows:

(i) For group life insurance policies, if the insured's total disability begins on or after the date the insured attains 60 years of age, the insurer is not required to waive premiums or monthly deductions. This subdivision does not preclude the insurer from extending a supplemental benefit for longer periods.

(ii) When a renewal is offered for a group life insurance policy that was issued prior to January 1, 2017, and contains a supplemental benefit described in this subparagraph, the insurer shall offer to renew the policy with a continuation of the in-force supplemental benefit, and may concurrently offer the group policyholder the option to change the supplemental benefit as described in clause (i).

(6) In addition to the permissible exclusions listed in subdivision (g) of Section 10271, the insurer may exclude a total disability occurring after the policy anniversary or supplemental contract anniversary, as applicable and as defined by the supplemental benefit, on which the insured attains a specified age of no less than 65 years.

(b) "Special surrender benefit" means a "waiver of surrender charge benefit" wherein the insurer waives the surrender charge usually charged for a withdrawal of funds from the cash value of a life insurance contract or the account value of an annuity contract if the owner, insured, or annuitant, as applicable, meets any of the following criteria:

(1) The individual develops a terminal illness, as defined in subdivision (d).

(2) The individual is receiving, as prescribed by a physician, registered nurse, or licensed social worker, home care or community-based services, as defined in subdivision (a) of Section 10232.9, or is confined in a skilled nursing facility, convalescent nursing home, or extended care facility, which shall not be defined more restrictively than as in the Medicare program, or is confined in a residential care facility or residential care facility for the elderly, as defined in the Health and Safety Code. Out-of-state providers of services shall be defined as comparable in licensure and staffing requirements to California providers.

(3) The individual has any medical condition that would, in the absence of treatment, result in death within a limited period of time, as defined by the supplemental benefit, but that shall not be restricted to a period of less than six months.

(4) (A) The individual is totally disabled, as follows:

(i) During the first 24 months of total disability, the owner, insured, or annuitant, as applicable, is unable to perform with reasonable continuity the substantial and material duties of their job due to sickness or bodily injury.

(ii) After the first 24 months of total disability, the owner, insured, or annuitant, as applicable, due to sickness or bodily injury, is unable to engage with reasonable continuity in any other job in which they could reasonably be expected to perform satisfactorily in light of their age, education, training, experience, station in life, or physical and mental capacity.

(B) The definition of total disability may also include presumptive total disability, such as the insured's total and permanent loss of sight of both eyes, hearing of both ears, speech, the use of both hands, both feet, or one hand and one foot.

(C) The insurer may require the total disability to continue for an uninterrupted period of time specified by the supplemental benefit, or the insurer may allow separate periods of disability to be combined.

(5) The individual has a chronic illness as defined in either subparagraph (A) or (B):

(A) Either of the following:

(i) Impairment in performing two out of seven activities of daily living, as set forth in subdivisions (a) and (g) of Section 10232.8, meaning the insured needs human assistance, or needs continual substantial supervision.

(ii) The insured has an impairment of cognitive ability, meaning a deterioration or loss of intellectual capacity due to mental illness or disease, including Alzheimer's disease or related illnesses, that requires continual supervision to protect oneself or others.

(B) Either of the following:

(i) Impairment in performing two out of six activities of daily living as described in subdivisions (b), (d), (e), and (f) of Section 10232.8 due to a loss of functional capacity to perform the activity.

(ii) Impairment of cognitive ability, meaning the insured needs substantial supervision due to severe cognitive impairment, as described in subdivisions (b), (d), and (e) of Section 10232.8.

(6) The individual has become involuntarily or voluntarily unemployed.

(c) "Supplemental benefit" means a rider to or provision in a life insurance policy, certificate, or annuity contract that provides a benefit as set forth in subdivision (a) of Section 10271.

(d) "Terminal illness benefit" means a provision, endorsement, or rider added to a life insurance policy that provides for the advance payment of any part of the death proceeds, payable upon the occurrence of a terminal illness. For the purposes of this chapter, "terminal illness" means a medical condition in which the owner's, insured's, or annuitant's life expectancy is expected to be less than or equal to a limited period of time that shall not be restricted to a period of less than 12 months or greater than 24 months.

(Amended by Stats. 2021, Ch. 627, Sec. 14. (AB 1511) Effective January 1, 2022.)

10272. The term "indemnity," as used in this chapter means benefits promised.

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

10273. The term "noncancelable policy" or "noncancelable and guaranteed renewable policy" as used in this chapter means a policy which the insured has the right to continue in force subject to its terms by the timely payment of premiums in the amount originally set forth in the policy (a) until at least age 50, or (b) in the case of a policy issued after age 44, for at least five years from its date of issue, during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force. Such a policy may use any of the provisions in Section 10291.6, 10350.2, 10350.4 or 10369.7, which may be used in noncancelable policies.

(Amended by Stats. 1961, Ch. 2047.)

10273.3. The term "guaranteed renewable policy" as used in this chapter (commencing with Section 10270) means a policy which the insured has the right to continue in force subject to its terms by the timely payment of premium (a) until at least age 50, or (b) in the case of a policy issued after age 44, for at least five years from its date of issue during which period the insurer has no right to make unilaterally any change in any provision of the policy while the policy is in force, except that the insurer may, in accordance with the provisions of the policy, make changes in premium rates as to all insureds who were placed in the same class for purposes of rate determination in the process of issuance of the policy or making it guaranteed renewable. Such a policy may use any of the provisions in Section 10291.6, 10350.2, 10350.4 or 10369.7, which may be used in noncancelable policies.

(Added by Stats. 1961, Ch. 2047.)

10273.4. All disability insurers writing, issuing, or administering group health benefit plans shall make all of these health benefit plans renewable with respect to the policyholder, contractholder, or employer except in case of the following:

(a) (1) Nonpayment of the required premiums by the policyholder, contractholder, or employer if the policyholder, contractholder, or employer has been duly notified and billed for the premium and at least a 30-day grace period has elapsed since the date of notification or, if longer, the period of time required for notice and any other requirements pursuant to Section 2703, 2712, or 2742 of the federal Public Health Service Act (42 U.S.C. Secs. 300gg-2, 300gg-12, and 300gg-42) and any subsequent rules or regulations has elapsed.

(2) Pursuant to paragraph (1), the disability insurer shall continue to provide coverage as required by the policyholder's, certificate holder's, or other insured's policy during the period described in paragraph (1).

(b) The insurer demonstrates fraud or an intentional misrepresentation of material fact under the terms of the policy by the policyholder, contractholder, or employer.

(c) Violation of a material contract provision relating to employer or other group contribution or group participation rates by the contractholder or employer.

(d) The insurer ceases to provide or arrange for the provision of health care services for new group health benefit plans in this state, provided that the following conditions are satisfied:

(1) Notice of the decision to cease writing, issuing, or administering new or existing group health benefit plans in this state is provided to the commissioner and to either the policyholder, contractholder, or employer at least 180 days prior to discontinuation of that coverage.

(2) Group health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a plan that remains in force, any disability insurer that ceases to write, issue, or administer new group health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(3) Except as provided under subdivision (h) of Section 10705, or unless the commissioner had made a determination pursuant to Section 10712, a disability insurer that ceases to write, issue, or administer new group health benefit plans in this state after the effective date of this section shall be prohibited from writing, issuing, or administering new group health benefit plans to employers in this state for a period of five years from the date of notice to the commissioner.

(e) The disability insurer withdraws a group health benefit plan from the market; provided, that the plan notifies all affected contractholders, policyholders, or employers and the commissioner at least 90 days prior to the discontinuation of the health benefit plans, and that the insurer makes available to the contractholder, policyholder, or employer all health benefit plans that it makes available to new employer business without regard to the claims experience of health-related factors of insureds or individuals who may become eligible for the coverage.

(f) If the coverage is offered through a network plan, there is no longer any covered individual in connection with the plan who lives, resides, or works in the service area of the disability insurer.

(g) If coverage is made available in the individual market through a bona fide association, the membership of the individual in the association on the basis of which the coverage is provided, ceases, but only if that coverage is terminated under this subdivision uniformly without regard to any health status-related factor of covered individuals.

(h) For the purposes of this section, "health benefit plan" shall have the same meaning as in subdivision (a) of Section 10198.6 and Section 10198.61.

(i) For the purposes of this section, "eligible employee" shall have the same meaning as in Section 10700, except that it applies to all health benefit plans issued to employer groups of two or more employees.

(Amended by Stats. 2010, Ch. 658, Sec. 11. (AB 2470) Effective January 1, 2011.)

10273.5. No person shall cause or permit to be issued, circulated or used any representation that a policy defined in Section 10273.3 is "non-can," noncancelable (not cancelable) or noncancelable and guaranteed renewable.

No person shall cause or permit to be issued, circulated or used any representation concerning the right to continue a policy such as is defined in Section 10273.3 unless such representation contains a declaration of the terms under which the insurer has reserved the right to change the premium in a manner which shall not minimize or obscure the same.

Any person knowingly violating any provision of this section shall be subject to the penalties provided for misrepresentation by this code.

(Added by Stats. 1961, Ch. 2047.)

10273.6. All individual health benefit plans shall be renewable with respect to all eligible individuals or dependents at the option of the individual except as follows:

(a) (1) Except as otherwise specified in paragraph (3), for nonpayment of the required premiums by the individual if the individual has been duly notified and billed for the premium and at least a 30-day grace period has elapsed since the date of notification or, if longer, the period of time required for notice and any other requirements pursuant to Section 2703, 2712, or 2742 of the federal Public Health Service Act (42 U.S.C. Secs. 300gg-2, 300gg-12, and 300gg-42) and subsequent rules or regulations has elapsed.

(2) Pursuant to paragraph (1), the disability insurer shall continue to provide coverage as required by the policyholder's, certificate holder's, or other insured's policy during the period described in paragraph (1).

(3) For nonpayment of the required premiums by an individual who receives advance payments of the premium tax credit authorized by Section 36B of the Internal Revenue Code or advanced premium assistance subsidy authorized by Section 100800 of the Government Code, or both, if the individual has been duly notified and billed for the charge and a grace period of three consecutive months has elapsed since the last day of paid coverage.

(A) During the first month of the three-month grace period described in paragraph (3), an insurer shall continue to do both of the following:

(i) Collect advance payments of the federal premium tax credit or state advanced premium assistance subsidy, or both, on behalf of the insured.

(ii) Provide coverage as required by the individual's policy.

(B) If the individual exhausts the three-month grace period described in paragraph (3) without paying all outstanding premiums due, the insurer shall return both of the following:

(i) Advance payments of the premium tax credit paid on behalf of the individual for the second and third months of the three-month grace period described in paragraph (3), pursuant to Section 156.270(e)(2) of Title 45 of the Code of Federal Regulations.

(ii) The advanced premium assistance subsidy paid on behalf of the individual for the second and third months of the three-month grace period described in paragraph (3), pursuant to subdivision (a) of Section 100805 of the Government Code.

(C) An insurer shall comply with all federal and state laws and regulations relating to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advance payments of the federal premium tax credit or state advanced premium assistance subsidy. For a health insurance contract issued, amended, or renewed on or after January 1, 2020, all requirements applicable to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive advance payments of premium tax credit authorized by Section 36B of the Internal Revenue Code shall apply to cancellations, terminations, or nonrenewals of coverage due to nonpayment of premiums by individuals who receive premium assistance subsidy authorized by Section 100800 of the Government Code.

(b) The insurer demonstrates fraud or intentional misrepresentation of material fact under the terms of the policy by the individual.

(c) Movement of the individual contractholder outside the service area, but only if coverage is terminated uniformly without regard to a health status-related factor of covered individuals.

(d) If the disability insurer ceases to provide or arrange for the provision of health care services for new individual health benefit plans in this state, as long as the following conditions are satisfied:

(1) Notice of the decision to cease new or existing individual health benefit plans in this state is provided to the commissioner and to the individual policy or contractholder at least 180 days before discontinuation of that coverage.

(2) Individual health benefit plans shall not be canceled for 180 days after the date of the notice required under paragraph (1) and for that business of a disability insurer that remains in force, a disability insurer that ceases to offer for sale new individual health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(3) A disability insurer that ceases to write new individual health benefit plans in this state after the effective date of this section shall be prohibited from offering for sale individual health benefit plans in this state for a period of five years from the date of notice to the commissioner.

(e) If the disability insurer withdraws an individual health benefit plan from the market, as long as the disability insurer notifies all affected individuals and the commissioner at least 90 days before the discontinuation of these plans, and the disability insurer makes available to the individual all health benefit plans that it makes available to new individual businesses without regard to a health status-related factor of enrolled individuals or individuals who may become eligible for the coverage.

(f) If coverage is made available in the individual market through a bona fide association, and the membership of the individual in the association on the basis of which the coverage is provided ceases, but only if that coverage is terminated under this subdivision uniformly without regard to a health status-related factor of covered individuals.

(g) For the purposes of this section, "health benefit plan" has the same meaning as in subdivision (a) of Section 10198.6 and Section 10198.61.

(Amended by Stats. 2021, Ch. 627, Sec. 15. (AB 1511) Effective January 1, 2022.)

10273.7. (a) A policyholder, certificate holder, or other insured who alleges that a policy or coverage has been or will be canceled, rescinded, or not renewed in violation of Section 10713, 10273.4, 10273.6, 10384.17, or 10384, or any regulations promulgated thereunder, may request a review by the commissioner.

(b) If the commissioner determines that a proper complaint exists, the commissioner shall notify the insurer and the policyholder, certificate holder, or other insured. The insurer shall either request a hearing or reinstate the policyholder, certificate holder, or other insured.

(c) If, after review, the commissioner determines that the cancellation, rescission, or failure to renew is contrary to existing law, the commissioner shall order the insurer to reinstate the policyholder, certificate holder, or other insured. Within 15 days after receipt of that order, the insurer shall either request a hearing or reinstate the policyholder, certificate holder, or other insured.

(d) If a policyholder, certificate holder, or other insured requests a review of the insurer's determination to cancel, rescind, or failure to renew the policyholder's, certificate holder's, or other insured's policy or coverage pursuant to subdivision (a), the insurer shall continue to provide coverage to the policyholder, certificate holder, or other insured under the terms of the contract or policy until a final determination of the policyholder, certificate holder, or other insured's request for review has been made by the commissioner. This subdivision shall not apply if the insurer cancels the policy or coverage for nonpayment of premiums pursuant to Section 10713, 10273.4, 10273.6, 10384.17, or 10384, or any regulations promulgated thereunder.

(e) A reinstatement pursuant to this section shall be retroactive to the time of cancellation, rescission, or failure to renew and the insurer shall be liable for the expenses incurred by the policyholder, certificate holder, or other insured for covered health care services from the date of cancellation, rescission, or nonrenewal to and including the date of reinstatement. The insurer shall reimburse the policyholder, certificate holder, or insured for any expenses incurred pursuant to this subdivision within 30 days of receipt of the completed claim.

(f) This section shall not abrogate any preexisting contracts or policies entered into prior to January 1, 2011, between a policyholder, certificate holder, or other insured and an insurer, except that each insurer shall, if directed to do so by the commissioner, exercise its authority, if any, under any such preexisting contracts or policies to conform them to the provisions of existing law.

(g) On or before July 1, 2011, the commissioner may issue guidance regarding compliance with this section and Sections 10713, 10273.4, 10273.6, 10384.17, and 10384, or any regulations promulgated under those provisions. 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 guidance shall only be effective through December 31, 2013, or until the commissioner adopts and effects regulations pursuant to the Administrative Procedure Act, whichever occurs first.

(h) To the extent required by Section 2719 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-19) and any subsequent rules or regulations, there shall be an independent external review pursuant to the standards required by the United States Secretary of Health and Human Services of an insurer's cancellation, rescission, or nonrenewal of a policyholder's, certificate holder's, or other insured's coverage.

(Added by Stats. 2010, Ch. 658, Sec. 13. (AB 2470) Effective January 1, 2011.)

10274. The term "endorsement" as used in this chapter means any amendment, change, limitation, alteration or restriction of the printed text of a policy by a rider upon a separate piece of paper made a part of such policy.

(Added by Stats. 1951, Ch. 570.)

10275. The term "policy of accident and sickness insurance" as used in this chapter includes any policy or contract covering the kind or kinds of insurance described in Section 106.

(Added by Stats. 1951, Ch. 570.)

10276. Every individual accident and health policy or contract, except single premium nonrenewable policies or contracts, issued for delivery in this state on or after July 1, 1962, by an insurance company, nonprofit hospital service plan or medical service corporation, shall have printed thereon or attached thereto a notice stating that the person to whom the policy or contract is issued shall be permitted to return the policy or contract after its delivery to the purchaser and to have the premium paid refunded if, after examination of the policy or contract, the purchaser is not satisfied with it for any reason. The period time set forth by the insurer, nonprofit hospital service plan or medical service corporation for return of the policy or contract shall be clearly stated on the notice and such period shall not be less than 10 days nor more than 30 days. The policyholder or purchaser may return the policy or contract to the insurer, plan or corporation at any time during the period specified in the notice. If a policyholder or purchaser pursuant to such notice, returns the policy or contract to the company or association at its home or branch office or to the agent through whom it was purchased, it shall be void from the beginning and the parties shall be in the same position as if no policy or contract had been issued.

This section shall apply to all policies or contracts subject to this section and issued, amended, delivered, or renewed in this state on or after January 1, 1981. All policies or contracts subject to this section which are in effect on January 1, 1981, shall be construed to be in compliance with this section, and any provision in any such policy or contract which is in conflict with this section shall be of no force or effect.

(Amended by Stats. 1980, Ch. 320, Sec. 2.)

10277. (a) A group health insurance policy that provides that coverage of a dependent child of an employee or other member of the covered group shall terminate upon attainment of the limiting age for dependent children specified in the policy, shall also provide that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to meet both of the following criteria:

(1) Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition.

(2) Chiefly dependent upon the employee or member for support and maintenance.

(b) The insurer shall notify the employee or member that the dependent child's coverage will terminate upon attainment of the limiting age unless the employee or member submits proof of the criteria described in paragraphs (1) and (2) of subdivision (a) to the insurer within 60 days of the date of receipt of the notification. The insurer shall send this notification to the employee or member at least 90 days prior to the date the child attains the limiting age. Upon receipt of a request by the employee or member for continued

coverage of the child and proof of the criteria described in paragraphs (1) and (2) of subdivision (a), the insurer shall determine whether the dependent child meets that criteria before the child attains the limiting age. If the insurer fails to make the determination by that date, it shall continue coverage of the child pending its determination.

(c) The insurer may subsequently request information about a dependent child whose coverage is continued beyond the limiting age under subdivision (a), but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

(d) If the employee or member changes carriers to another insurer or to a health care service plan, the new insurer or plan shall continue to provide coverage for the dependent child. The new plan or insurer may request information about the dependent child initially and not more frequently than annually thereafter to determine if the child continues to satisfy the criteria in paragraphs (1) and (2) of subdivision (a). The employee or member shall submit the information requested by the new plan or insurer within 60 days of receiving the request.

(e) If a group health insurance policy provides coverage for a dependent child who is over 26 years of age and enrolled as a full-time student at a secondary or postsecondary educational institution, the following shall apply:

(1) Any break in the school calendar shall not disqualify the dependent child from coverage.

(2) If the dependent child takes a medical leave of absence, and the nature of the dependent child's injury, illness, or condition would render the dependent child incapable of self-sustaining employment, the provisions of subdivision (a) shall apply if the dependent child is chiefly dependent on the policyholder for support and maintenance.

(3) (A) If the dependent child takes a medical leave of absence from school, but the nature of the dependent child's injury, illness, or condition does not meet the requirements of paragraph (2), the dependent child's coverage shall not terminate for a period not to exceed 12 months or until the date on which the coverage is scheduled to terminate pursuant to the terms and conditions of the policy, whichever comes first. The period of coverage under this paragraph shall commence on the first day of the medical leave of absence from the school or on the date the physician determines the illness prevented the dependent child from attending school, whichever comes first. Any break in the school calendar shall not disqualify the dependent child from coverage under this paragraph.

(B) Documentation or certification of the medical necessity for a leave of absence from school shall be submitted to the insurer at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the start date of the medical leave of absence from school and shall be considered prima facie evidence of entitlement to coverage under this paragraph.

(4) This subdivision shall not apply to a policy of specialized health insurance, Medicare supplement insurance, CHAMPUS-supplement or TRICARE-supplement insurance policies, or to hospital-only, accident-only, or specified disease insurance policies that reimburse for hospital, medical, or surgical benefits.

(f) (1) Except as set forth in paragraph (2), under no circumstances shall the limiting age under a group or individual health insurance policy that provides coverage of a dependent child be less than 26 years of age with respect to policy years beginning on or after September 23, 2010.

(2) For policy years beginning before January 1, 2014, a group health insurance policy that qualifies as a grandfathered health plan under Section 1251 of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and that makes available dependent coverage of children may exclude from coverage an adult child who has not attained the age of 26 years only if the adult child is eligible to enroll in an eligible employer-sponsored health plan, as defined in Section 5000A(f)(2) of the Internal Revenue Code, other than a group health plan or policy of a parent.

(3) (A) With respect to a child (i) whose coverage under a group or individual health insurance policy ended, or who was denied or not eligible for coverage under a group or individual health insurance policy, because under the terms of the policy the availability of dependent coverage of children ended before the attainment of 26 years of age, and (ii) who becomes eligible for that coverage by reason of the application of this subdivision, the health insurer shall give the child an opportunity to enroll that shall continue for at least 30 days. This opportunity and the notice described in subparagraph (B) shall be provided not later than the first day of the first policy year beginning on or after September 23, 2010, consistent with 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 additional federal guidance or regulations issued by the United States Secretary of Health and Human Services.

(B) The health insurer shall provide written notice stating that a dependent described in subparagraph (A) who has not attained the age of 26 years is eligible to apply for coverage. This notice may be provided to the dependent's parent on behalf of the dependent. If the notice is included with enrollment materials for a group policy, the notice shall be prominent.

(C) In the case of an individual who enrolls under this paragraph, coverage shall take effect no later than the first day of the first policy year beginning on or after September 23, 2010.

(D) A dependent enrolling in coverage under a group policy pursuant to this paragraph shall be treated as a special enrollee as provided under the rules of Section 146.117(d) of Title 45 of the Code of Federal Regulations. The health insurer shall offer the recipient of the notice all of the benefit packages available to similarly situated individuals who did not lose coverage by reason of cessation of dependent status. Any difference in benefit or cost-sharing requirements shall constitute a different benefit package. A dependent enrolling in coverage under a group policy pursuant to this paragraph shall not be required to pay more for coverage than similarly situated individuals who did not lose coverage by reason of cessation of dependent status.

(4) Nothing in this section shall require a health insurer to make coverage available for a child of a child receiving dependent coverage. Nothing in this section shall be construed to modify the definition of "dependent" as used in the Revenue and Taxation Code with respect to the tax treatment of the cost of coverage.

(Amended by Stats. 2010, Ch. 660, Sec. 2. (SB 1088) Effective January 1, 2011.)

10278. (a) An individual health insurance policy that provides that coverage of a dependent child shall terminate upon attainment of the limiting age for dependent children specified in the policy, shall also provide that attainment of the limiting age shall not operate to terminate the coverage of the child while the child is and continues to meet both of the following criteria:

(1) Incapable of self-sustaining employment by reason of a physically or mentally disabling injury, illness, or condition.

(2) Chiefly dependent upon the policyholder or subscriber for support and maintenance.

(b) The insurer shall notify the policyholder or subscriber that the dependent child's coverage will terminate upon attainment of the limiting age unless the policyholder or subscriber submits proof of the criteria described in paragraphs (1) and (2) of subdivision (a) to the insurer within 60 days of the date of receipt of the notification. The insurer shall send this notification to the policyholder or subscriber at least 90 days prior to the date the child attains the limiting age. Upon receipt of a request by the policyholder or subscriber for continued coverage of the child and proof of the criteria described in paragraphs (1) and (2) of subdivision (a), the insurer shall determine whether the dependent child meets that criteria before the child attains the limiting age. If the insurer fails to make the determination by that date, it shall continue coverage of the child pending its determination.

(c) The insurer may subsequently request information about a dependent child whose coverage is continued beyond the limiting age under subdivision (a), but not more frequently than annually after the two-year period following the child's attainment of the limiting age.

(d) If the subscriber or policyholder changes carriers to another insurer or to a health care service plan, the new insurer or plan shall continue to provide coverage for the dependent child. The new plan or insurer may request information about the dependent child initially and not more frequently than annually thereafter to determine if the child continues to satisfy the criteria in paragraphs (1) and (2) of subdivision (a). The subscriber or policyholder shall submit the information requested by the new plan or insurer within 60 days of receiving the request.

(e) If an individual health insurance policy provides coverage for a dependent child who is over 18 years of age and enrolled as a full-time student at a secondary or postsecondary educational institution, the following shall apply:

(1) Any break in the school calendar shall not disqualify the dependent child from coverage.

(2) If the dependent child takes a medical leave of absence, and the nature of the dependent child's injury, illness, or condition would render the dependent child incapable of self-sustaining employment, the provisions of subdivision (a) shall apply if the dependent child is chiefly dependent on the policyholder for support and maintenance.

(3) (A) If the dependent child takes a medical leave of absence from school, but the nature of the dependent child's injury, illness, or condition does not meet the requirements of paragraph (2), the dependent child's coverage shall not terminate for a period not to exceed 12 months or until the date on which the coverage is scheduled to terminate pursuant to the terms and conditions of the policy, whichever comes first. The period of coverage under this paragraph shall commence on the first day of the medical leave of absence from the school or on the date the physician determines the illness prevented the dependent child from attending school, whichever comes first. Any break in the school calendar shall not disqualify the dependent child from coverage under this paragraph.

(B) Documentation or certification of the medical necessity for a leave of absence from school shall be submitted to the insurer at least 30 days prior to the medical leave of absence from the school, if the medical reason for the absence and the absence are foreseeable, or 30 days after the start date of the medical leave of absence from school and shall be considered prima facie evidence of entitlement to coverage under this paragraph.

(4) This subdivision shall not apply to a policy of specialized health insurance, Medicare supplement insurance, CHAMPUS-supplement, or TRICARE-supplement insurance policies, or to hospital-only, accident-only, or specified disease insurance policies

that reimburse for hospital, medical, or surgical benefits.

(Amended by Stats. 2008, Ch. 390, Sec. 3. Effective January 1, 2009.)

10278.1. (a) An individual health insurance policy issued, amended, or renewed on or after January 1, 2023, that provides dependent coverage shall make dependent coverage available to a parent or stepparent who meets the definition of a qualifying relative under Section 152(d) of Title 26 of the United States Code and who lives or resides within the health insurer's service area.

(b) It is the intent of the Legislature to ensure that individuals who are seeking to add to their policy a dependent parent or stepparent who is eligible for or enrolled in Medicare are informed of and understand their specific rights and health care options before enrolling them in an individual health insurance policy, including the potential benefits, financial assistance, and tax liability under those options.

(c) If an applicant is seeking to add to their policy a dependent parent or stepparent who is eligible for or enrolled in Medicare:

(1) A health insurer shall provide, at the time of solicitation and on the application, to an applicant who does not apply through the California Health Benefit Exchange written notice that the Health Insurance Counseling and Advocacy Program (HICAP) provides health insurance counseling to senior California residents free of charge, including the name, address, and telephone number of the local HICAP program and the statewide HICAP telephone number, 1-800-434-0222.

(2) The California Health Benefit Exchange shall provide to an applicant who applies through the California Health Benefit Exchange written notice that HICAP provides health insurance counseling to senior California residents free of charge, including the name, address, and telephone number of the local HICAP program and the statewide HICAP telephone number, 1-800-434-0222.

(3) An agent shall provide the name, address, and telephone number of the local HICAP program and the statewide HICAP telephone number, 1-800-434-0222, at the time of solicitation.

(d) This section does not apply to specialized health insurance, Medicare supplement insurance, CHAMPUS supplement insurance, or TRICARE supplement insurance, or to hospital-only, accident-only, or specified disease insurance policies that reimburse for hospital, medical, or surgical benefits.

(Amended by Stats. 2022, Ch. 118, Sec. 2. (AB 2127) Effective January 1, 2023.)

10279. (a) Every disability insurer that provides group or individual policies of disability, or both, that provides, operates, or contracts for, telephone medical advice services to its insureds shall do all of the following:

(1) Ensure that the in-state or out-of-state telephone medical advice service complies with the requirements of Chapter 15 (commencing with Section 4999) of Division 2 of the Business and Professions Code.

(2) Ensure that the staff providing telephone medical advice services for the in-state or out-of-state telephone medical advice service hold a valid California license as a registered nurse or a valid license in the state within which they provide telephone medical advice services as a physician and surgeon or physician assistant and are operating consistent with the laws governing their respective scopes of practice.

(3) Ensure that a physician and surgeon is available on an on-call basis at all times the service is advertised to be available to enrollees and subscribers.

(4) Ensure that the in-state or out-of-state telephone medical advice service designates an agent for service of process in California and files this designation with the commissioner.

(5) Require that the in-state or out-of-state telephone medical advice service makes and maintains records for a period of five years after the telephone medical advice services are provided, including, but not limited to, oral or written transcripts of all medical advice conversations with the disability insurer's insureds in California and copies of all complaints. If the records of telephone medical advice services are kept out of state, the insurer shall, upon the request of the director, provide the records to the director within 10 days of the request.

(6) Ensure that the telephone medical advice services are provided consistent with good professional practice.

(b) The commissioner shall forward to the Department of Consumer Affairs, within 30 days of the end of each calendar quarter, data regarding complaints filed with the department concerning telephone medical advice services.

(Amended by Stats. 2016, Ch. 799, Sec. 43. (SB 1039) Effective January 1, 2017.)

