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 7. Disability Insurance Disclosure [10600 - 10609] *(Chapter 7 added by Stats. 1974, Ch. 936.)*

10600. This part shall be known and may be referred to as the “Health Insurance Disclosure Act of 1974.”

(Added by Stats. 1974, Ch. 936.)

10601. As used in this chapter:

(a) “Benefits and coverage” means the accident, sickness or disability indemnity available under a policy of disability insurance.

(b) “Exception” means any provision in a policy whereby coverage for a specified hazard or condition is entirely eliminated.

(c) “Reduction” means any provision in a policy which reduces the amount of a policy benefit to some amount or period less than would be otherwise payable for medically authorized expenses or services had such a reduction not been used.

(d) “Limitation” means any provision other than an exception or a reduction which restricts coverage under the policy.

(e) “Presenting for examination or sale” means either (1) publication and dissemination of any brochure, mailer, advertisement, or form which constitutes a presentation of the provisions of the policy and which provides a policy enrollment or application form, or (2) consultations or discussions between prospective beneficiaries or their contract agents and employees or agents of disability insurers, when such consultations or discussions include presentation of formal, organized information about the policy which is intended to influence or inform the prospective insured or beneficiary, such as brochures, summaries, charts, slides, or other modes of information in lieu of or in addition to the policy itself.

(f) “Disability insurance” means every policy of disability insurance, self-insured employee welfare benefit plan, and nonprofit hospital service plan issued, delivered, or entered into pursuant to or described in Chapter 1 (commencing with Section 10110), Chapter 4 (commencing with Section 10270), or Chapter 11A (commencing with Section 11491) of this part.

(g) “Insurer” means every insurer transacting disability insurance, every self-insured employee welfare plan, and every nonprofit hospital service plan specified in subdivision (e).

(h) “Disclosure form” means the standard supplemental disclosure form required pursuant to Section 10603.

(Added by Stats. 1974, Ch. 936.)

10602. For the purposes of this chapter, where the definition of the term “hospital” in the policy omits care in any “health facility” defined pursuant to subdivision (a) or (b) of Section 1250 of the Health and Safety Code, the omitted coverage shall constitute a limitation. Further, where the definition of the term “nursing home” in the policy omits care in any “health facility” defined pursuant to subdivision (c) or (d) of Section 1250 of the Health and Safety Code, the omitted coverage shall constitute a limitation.

(Added by Stats. 1974, Ch. 936.)

10602.1. Nothing in this chapter shall prevent an insurer which makes contracts with hospitals from distinguishing between contracting hospitals and noncontracting hospitals.

(Added by Stats. 1974, Ch. 936.)

10603. (a) (1) On or before April 1, 1975, the commissioner shall promulgate a standard supplemental disclosure form for all disability insurance policies. Upon the appropriate disclosure form as prescribed by the commissioner, each insurer shall provide, in easily understood language and in a uniform, clearly organized manner, as prescribed and required by the commissioner, the

summary information about each disability insurance policy offered by the insurer as the commissioner finds is necessary to provide for full and fair disclosure of the provisions of the policy.

(2) On and after January 1, 2014, a disability insurer offering health insurance coverage subject to Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15) shall satisfy the requirements of this section and the implementing regulations by providing the uniform summary of benefits and coverage required under Section 2715 of the federal Public Health Service Act and any rules or regulations issued thereunder. An insurer that issues the federal uniform summary of benefits referenced in this paragraph shall ensure that all applicable disclosures required in this chapter and its implementing regulations are met in other documents provided to policyholders and insureds. An insurer subject to this paragraph shall provide the uniform summary of benefits and coverage to the commissioner together with the corresponding health insurance policy pursuant to Section 10290.

(3) Commencing October 1, 2016, the uniform summary of benefits and coverage referenced in this subdivision shall constitute a vital document for the purposes of Section 10133.8. Not later than July 1, 2016, the commissioner shall develop written translations of the template uniform summary of benefits and coverage for all language groups identified by the State Department of Health Care Services in all plan letters as of August 27, 2014, for translation services pursuant to Section 14029.91 of the Welfare and Institutions Code, except for any language group for which the United States Department of Labor has already prepared a written translation. Not later than July 1, 2016, the commissioner shall make available on the department's Internet Web site written translations of the template uniform summary of benefits and coverage developed by the commissioner, and written translations prepared by the United States Department of Labor, if available, for any language group to which this subparagraph applies.

(b) This section does not preclude the disclosure form from being included with the evidence of coverage or certificate of coverage or policy.

(Amended by Stats. 2016, Ch. 86, Sec. 212. (SB 1171) Effective January 1, 2017.)

10603.04. (a) For policy years on and after January 1, 2021, or 12 months after regulations are adopted under subdivision (f), whichever occurs later, a health insurer that issues, sells, renews, or offers a policy that covers dental services in this state, in addition to any other applicable disclosure requirements, shall use a uniform benefits and coverage disclosure matrix, which shall be developed by the department, in conjunction with the Department of Managed Health Care, and in consultation with stakeholders. At a minimum, the benefits and coverage disclosure matrix shall require the health insurer to make available all of the following relating to covered dental services, together with the corresponding copayments or coinsurance and limitations:

(1) The annual overall policy deductible.

(2) The annual benefit limit.

(3) Coverage for the following categories:

(A) Preventive and diagnostic services.

(B) Basic services.

(C) Major services.

(D) Orthodontia services.

(4) Dental policy reimbursement levels and estimated insured cost share for service.

(5) Waiting periods.

(6) Examples to illustrate coverage and estimated insured costs of commonly used benefits. The examples shall include at least one service from each of the following categories listed in paragraph (3):

(A) Preventive and diagnostic services.

(B) Basic services.

(C) Major services.

(b) All health insurers, solicitors, and representatives of a health insurer that issue, sell, renew, or offer a policy that covers dental services shall, when presenting any policy for examination or sale to an individual prospective insured, make available to the individual a properly completed benefits and coverage disclosure matrix, as prescribed by the commissioner pursuant to this section for each dental policy examined or sold.

(c) In the case of group policies for dental services, the completed disclosures and coverage matrix and evidence of coverage shall be made available to the policyholder upon delivery of the completed policy for dental insurance.

(d) Group policyholders shall make available the completed benefits and coverage disclosure matrix to all persons eligible to be a policyholder under the group policy at the time those persons are offered the dental insurance. If the individual group members are offered a choice of dental policies, separate benefits and coverage disclosure matrices shall be made available for each dental policy offered. Each group policyholder shall also make available copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all policyholders insured under the group policy.

(e) The health insurer offering a policy that covers dental services in the individual, small, or large group market shall make available the benefits and coverage disclosure matrix to all individuals newly enrolling for coverage, experiencing a special enrollment event, and renewing coverage, and shall make available the benefits and coverage disclosure matrix to all other insureds upon request.

(f) (1) The department shall adopt emergency regulations pursuant to Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code to implement this section. The department shall consult with the Department of Managed Health Care in adopting the emergency regulations, as appropriate. The adoption of regulations pursuant to this section shall be deemed to be an emergency and necessary for the immediate preservation of the public peace, health, or safety.

(2) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, emergency regulations adopted pursuant to this section shall not be subject to the review and approval of the Office of Administrative Law. The regulations shall become effective immediately upon filing with the Secretary of State. The regulations shall not remain in effect more than 120 days unless the adopting agency complies with all of the provisions of Chapter 3.5 (commencing with Section 11340) as required by subdivision (c) of Section 11346.1 of the Government Code.

(g) This section does not apply to Medi-Cal dental managed care contracts authorized under Chapter 7 (commencing with Section 14000) and Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code.

(Added by Stats. 2018, Ch. 933, Sec. 5. (SB 1008) Effective January 1, 2019.)

10604. The disclosure form shall include the following information, in concise and specific terms, relative to the disability insurance policy:

(a) The applicable category or categories of coverage provided by the policy, from among the following:

(1) Basic hospital expense coverage.

(2) Basic medical-surgical expense coverage.

(3) Hospital confinement indemnity coverage.

(4) Major medical expense coverage.

(5) Disability income protection coverage.

(6) Accident only coverage.

(7) Specified disease or specified accident coverage.

(8) Such other categories as the commissioner may prescribe.

(b) The principal benefits and coverage of the disability insurance policy.

(c) The exceptions, reductions, and limitations that apply to such policy.

(d) A summary, including a citation of the relevant contractual provisions, of the process used to authorize or deny payments for services under the coverage provided by the policy including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. This subdivision shall only apply to policies of disability insurance that cover hospital, medical, or surgical expenses.

(e) The full premium cost of such policy.

(f) Any copayment, coinsurance, or deductible requirements that may be incurred by the insured or his family in obtaining coverage under the policy.

(g) The terms under which the policy may be renewed by the insured, including any reservation by the insurer of any right to change premiums.

(h) A statement that the disclosure form is a summary only, and that the policy itself should be consulted to determine governing contractual provisions.

(Amended by Stats. 1996, Ch. 1024, Sec. 6. Effective January 1, 1997.)

10604.1. (a) The Legislature finds and declares that the right of every patient to receive basic information necessary to give full and informed consent is a fundamental tenet of good public health policy and has long been the established law of this state. Some hospitals and other providers do not provide a full range of reproductive health services and may prohibit or otherwise not provide sterilization, infertility treatments, abortion, or contraceptive services, including emergency contraception. It is the intent of the Legislature that every patient be given full and complete information about the health care services available to allow patients to make well informed health care decisions.

(b) On or before July 1, 2001, every disability insurer that provides coverage for hospital, medical, or surgical benefits, and which provides a list of network providers to prospective insureds and insureds, shall do both of the following:

(1) Include the following statement, in at least 12-point boldface type, at the beginning of each provider directory:

"Some hospitals and other providers do not provide one or more of the following services that may be covered under your policy and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you become a policyholder or select a network provider. Call your prospective doctor or clinic, or call the insurer at (insert the insurer's membership services number or other appropriate number that individuals can call for assistance) to ensure that you can obtain the health care services that you need."

(2) Place the statement described in paragraph (1) in a prominent location on any provider directory posted on the insurer's website, if any, and include this statement in a conspicuous place in the insurer's evidence of coverage and disclosure forms.

(c) A disability insurer shall not be required to provide the statement described in paragraph (1) of subdivision (b) in a service area in which none of the hospitals, health facilities, clinics, medical groups, or independent practice associations with which it contracts limit or restrict any of the reproductive services described in the statement.

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

(Added by Stats. 2000, Ch. 347, Sec. 3. Effective January 1, 2001.)

10604.5. An insurer shall annually disclose to the governing board of a public agency that is the policyholder of a group health insurance policy, the name and address of, and amount paid to, any agent, broker, or individual to whom the insurer paid fees or commissions related to the public agency's group health insurance policy. As part of this disclosure, the insurer shall include the name, address, and amounts paid to the specific agents, brokers, or individuals involved in transactions with the public agency. The compensation disclosure required by this section is in addition to any other compensation disclosure requirements that exist under law.

(Added by Stats. 2008, Ch. 331, Sec. 2. Effective January 1, 2009.)

10605. (a) Effective July 1, 1976, all insurers, and their employees and agents, shall, when presenting any disability insurance policy for examination or sale to an individual prospective insured or individual prospective subscriber, provide such individual with a properly completed disclosure form, as prescribed by the commissioner pursuant to Sections 10603 and 10604, for each disability insurance policy so examined or sold.

(b) In the case of group disability insurance contracts, the completed disclosure form shall be presented to the contract holder upon delivery of the group policy or contract.

(c) Group insurance contract holders shall disseminate copies of the completed disclosure form to all persons or family units eligible under the group contract. Where the individual members of the group are offered a choice of policies, separate disclosure forms shall be supplied for each policy available.

(d) Disability insurance issued in connection with an employees' welfare plan subject to the Federal Employee Retirement Income Security Act of 1974 (P.L. 93-406) is exempt from the provisions of this chapter.

(Amended by Stats. 1975, Ch. 1208.)

10606. Effective July 1, 1976, where the commissioner finds it necessary in the interest of full and fair disclosure, all advertising and other consumer information, including brochures, disseminated by insurers for the purpose of influencing persons to purchase health

insurance shall contain such supplemental disclosure information as the commissioner may require.

(Amended by Stats. 1975, Ch. 1208.)

10607. In addition to the other disclosures required by this chapter, every insurer and their employees or agents shall, when presenting a plan for examination or sale to any individual or the representative of a group consisting of 25 or fewer individuals, disclose in writing the ratio of incurred claims to earned premiums (loss-ratio) for the insurer's preceding calendar year. This section shall become operative on March 1, 1991, in order to allow insurers time to comply with its provisions.

(Added by Stats. 1990, Ch. 1071, Sec. 2. Section operative March 1, 1991, by its own provisions.)

10608. The commissioner shall, from time to time as conditions warrant, after notice and public hearing, promulgate such reasonable rules and regulations, and amendments and additions thereto, as are necessary to administer this chapter.

(Added by Stats. 1974, Ch. 936.)

10609. Beginning on or before January 1, 1976, each insurer shall, to the extent required by the commissioner, file with the commissioner copies of all printed advertising which the insurer proposes to disseminate in the state.

(Added by renumbering Section 790.025 by Stats. 1975, Ch. 1208.)