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HEALTH AND SAFETY CODE - HSC

DIVISION 2. LICENSING PROVISIONS [1200 - 1796.70] (*Division 2 enacted by Stats. 1939, Ch. 60.*)

CHAPTER 2.2. Health Care Service Plans [1340 - 1399.874] (*Chapter 2.2 added by Stats. 1975, Ch. 941.*)

ARTICLE 4. Solicitation and Enrollment [1359 - 1366.6] (*Article 4 added by Stats. 1975, Ch. 941.*)

1359. (a) The director may require that solicitors and solicitor firms, and principal persons engaged in the supervision of solicitation for plans of solicitor firms, meet such reasonable and appropriate standards with respect to training, experience, and other qualifications as the director finds necessary and appropriate in the public interest or for the protection of subscribers, enrollees, and plans. For such purposes, the director may do the following:

- (1) Appropriately classify such persons and individuals.
- (2) Specify that all or any portion of such standards shall be applicable to any such class.
- (3) Require individuals in any such class to pass examinations prescribed in accordance with such rules.

(b) The director may prescribe by rule reasonable fees and charges to defray the costs of carrying out this section, including, but not limited to, fees for any examination administered by the director or under his or her direction.

(*Amended by Stats. 1999, Ch. 525, Sec. 85. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.*)

1360. (a) No plan, solicitor, solicitor firm, or representative shall use or permit the use of any advertising or solicitation which is untrue or misleading, or any form of evidence of coverage which is deceptive. For purposes of this article:

- (1) A written or printed statement or item of information shall be deemed untrue if it does not conform to fact in any respect which is, or may be significant to an enrollee or subscriber, or potential enrollee or subscriber in a plan.
- (2) A written or printed statement or item of information shall be deemed misleading whether or not it may be literally true, if, in the total context in which the statement is made or such item of information is communicated, such statement or item of information may be understood by a person not possessing special knowledge regarding health care coverage, as indicating any benefit or advantage, or the absence of any exclusion, limitation, or disadvantage of possible significance to an enrollee, or potential enrollee or subscriber, in a plan, and such is not the case.
- (3) An evidence of coverage shall be deemed to be deceptive if the evidence of coverage taken as a whole and with consideration given to typography and format, as well as language, shall be such as to cause a reasonable person, not possessing special knowledge of plans, and evidence of coverage therefor to expect benefits, service charges, or other advantages which the evidence of coverage does not provide or which the plan issuing such coverage or evidence of coverage does not regularly make available to enrollees or subscribers covered under such evidence of coverage.

(b) No plan, or solicitor, or representative shall use or permit the use of any verbal statement which is untrue, misleading, or deceptive or make any representations about coverage offered by the plan or its cost that does not conform to fact. All verbal statements are to be held to the same standards as those for printed matter provided in subdivision (a).

(*Added by Stats. 1975, Ch. 941.*)

1360.1. It is unlawful for any person, including a plan, subject to this chapter to represent or imply in any manner that the person or plan has been sponsored, recommended, or approved, or that the person's or plan's abilities or qualifications have in any respect been passed upon, by the director. Nothing in this section prohibits a statement (other than in a paid advertisement) that a person or plan holds a license under this chapter, if such statement is true and if the effect of such licensing is not misrepresented.

1360.5. (a) For purposes of this section, "Exchange" means the California Health Benefit Exchange established pursuant to Section 100500 of the Government Code.

(b) It is an unfair business practice for a solicitor or solicitor firm to hold himself, herself, or itself out as representing, constituting, or otherwise providing services on behalf of the Exchange unless the solicitor or solicitor firm has a valid agreement with the Exchange to engage in those activities.

(c) It is an unfair business practice for a health care service plan to hold itself out as representing, constituting, or otherwise providing services on behalf of the Exchange unless the plan has a valid agreement with the Exchange to engage in those activities.

(Added by Stats. 2012, Ch. 876, Sec. 2. (AB 1761) Effective January 1, 2013.)

1361. (a) Except as provided in subdivision (b), no plan shall publish or distribute, or allow to be published or distributed on its behalf, any advertisement not subject to Section 1352.1 unless (1) a true copy thereof has first been filed with the director, at least 30 days prior to any such use, or any shorter period as the director by rule or order may allow, and (2) the director by notice has not found the advertisement, wholly or in part, to be untrue, misleading, deceptive, or otherwise not in compliance with this chapter or the rules thereunder, and specified the deficiencies, within the 30 days or any shorter time as the director by rule or order may allow.

(b) Except as provided in subdivision (c), a licensed plan which has been continuously licensed under this chapter for the preceding 18 months may publish or distribute or allow to be published or distributed on its behalf an advertisement not subject to Section 1352.1 without having filed the same for the director's prior approval, if the plan and the material comply with each of the following conditions:

(1) The advertisement or a material provision thereof has not been previously disapproved by the director by written notice to the plan and the plan reasonably believes that the advertisement does not violate any requirement of this chapter or the rules thereunder.

(2) The plan files a true copy of each new or materially revised advertisement, used by it or by any person acting on behalf of the plan, with the director not later than 10 business days after publication or distribution of the advertisement or within such additional period as the director may allow by rule or order.

(c) If the director finds that any advertisement of a plan has materially failed to comply with this chapter or the rules thereunder, the director may, by order, require the plan to publish in the same or similar medium, an approved correction or retraction of any untrue, misleading, or deceptive statement contained in the advertising, and may prohibit the plan from publishing or distributing, or allowing to be published or distributed on its behalf the advertisement or any new materially revised advertisement without first having filed a copy thereof with the director, 30 days prior to the publication or distribution thereof, or any shorter period specified in the order. An order issued under this subdivision shall be effective for 12 months from its issuance, and may be renewed by order if the advertisements submitted under this subdivision indicate difficulties of voluntary compliance with the applicable provisions of this chapter and the rules thereunder.

(d) A licensed plan or other person regulated under this chapter may, within 30 days after receipt of any notice or order under this section, file a written request for a hearing with the director.

(e) The director by rule or order may classify plans and advertisements and exempt certain classes, wholly or in part, either unconditionally or upon specified terms and conditions or for specified periods, from the application of subdivisions (a) and (b).

(Amended by Stats. 1999, Ch. 525, Sec. 87. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1361.1. (a) It is an unfair business practice for a solicitor, solicitor firm, or representative of a health care service plan to sell, solicit, or negotiate the purchase of health care coverage products by any of the following methods:

(1) The use of a marketing technique known as cold lead advertising when marketing a Medicare product. As used in this section, "cold lead advertising" means making use directly or indirectly of a method of marketing that fails to disclose in a conspicuous manner that a purpose of the marketing is health care service plan sales solicitation and that contact will be made by a solicitor, solicitor firm, or representative of a health care service plan.

(2) The use of an appointment that was made to discuss a particular Medicare product or to solicit the sale of a particular Medicare product in order to solicit the sale of another Medicare product or other health care coverage products, unless the consumer specifically agrees in advance of the appointment to discuss that other Medicare product or other types of health care coverage products during the same appointment.

(b) As used in this section, "Medicare product" includes Medicare Parts A, B, C, and D, and Medicare supplement plans.

(Amended by Stats. 2009, Ch. 140, Sec. 97. (AB 1164) Effective January 1, 2010.)

1362. As used in Sections 1363 and 1364:

- (a) "Benefits and coverage" means the health care services available under a plan contract.
- (b) "Exception" means any provision in a plan contract whereby coverage for a specified hazard or condition is entirely eliminated.
- (c) "Reduction" means any provision in a plan contract which reduces the amount of a plan 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 plan.
- (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 plan and which provides a plan enrollment or application form, or (2) consultations or discussions between prospective plan members or their contract agents and solicitors or representatives of a plan, when such consultations or discussions include presentation of formal, organized information about the plan which is intended to influence or inform the prospective member or contract holder, such as brochures, summaries, charts, slides, or other modes of information.
- (f) "Disclosure form" means the disclosure form, material, or information required pursuant to Section 1363.
- (g) For the purposes of Sections 1363 and 1364, where the definition of the term "hospital" in the plan contract omits care in any "health facility" defined pursuant to subdivision (a) or (b) of Section 1250 of this code, the omitted coverage shall constitute a limitation; and where the definition of the term "nursing home" in the plan omits care in any "health facility" defined pursuant to subdivision (c) or (d) of Section 1250 of this code, the omitted coverage shall constitute a limitation.

(Added by Stats. 1975, Ch. 941.)

1363. (a) (1) The director shall require the use by each plan of disclosure forms or materials containing information regarding the benefits, services, and terms of the plan contract as the director may require, so as to afford the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. Health care service plans shall present the materials in the uniform manner established by the department pursuant to paragraph (2) so as to facilitate comparisons between plan contracts of the same or other types of plans. Nothing contained in this chapter shall preclude the director from permitting the disclosure form to be included with the evidence of coverage or plan contract.

(2) The department shall develop standard templates for the disclosure form and evidence of coverage. The standard templates for the disclosure form and evidence of coverage may be consolidated into a single standard template. The standard template or templates may include standard definitions, notice and explanatory language, benefit and limitation descriptions, and any other information or formatting in the template that the director determines, consistent with the goals of this section. The department shall consult with the Department of Insurance and interested stakeholders in developing standard templates under this section.

(b) The disclosure form shall provide for at least the following information, in concise and specific terms, relative to the plan, together with additional information as may be required by the director, in connection with the plan or plan contract:

(1) The principal benefits and coverage of the plan, including coverage for acute care and subacute care.

(2) The exceptions, reductions, and limitations that apply to the plan.

(3) The full premium cost of the plan.

(4) Any copayment, coinsurance, or deductible requirements that may be incurred by the member or the member's family in obtaining coverage under the plan.

(5) The terms under which the plan may be renewed by the plan member, including any reservation by the plan of any right to change premiums.

(6) A statement that the disclosure form is a summary only, and that the plan contract itself should be consulted to determine governing contractual provisions. The first page of the disclosure form shall contain a notice that conforms with all of the following conditions:

(A) (i) States that the evidence of coverage discloses the terms and conditions of coverage.

(ii) States, with respect to individual plan contracts, small group plan contracts, and any other group plan contracts for which health care services are not negotiated, that the applicant has a right to view the evidence of coverage prior to enrollment, and, if the evidence of coverage is not combined with the disclosure form, the notice shall specify where the evidence of coverage can be obtained prior to enrollment.

(B) Includes a statement that the disclosure and the evidence of coverage should be read completely and carefully and that individuals with special health care needs should read carefully those sections that apply to them.

(C) Includes the plan's telephone number or numbers that may be used by an applicant to receive additional information about the benefits of the plan or a statement where the telephone number or numbers are located in the disclosure form.

(D) For individual contracts, and small group plan contracts as defined in Article 3.1 (commencing with Section 1357), the disclosure form shall state where the health plan benefits and coverage matrix is located.

(E) Is printed in type no smaller than that used for the remainder of the disclosure form and is displayed prominently on the page.

(7) A statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon an enrollee who is hospitalized or undergoing treatment for an ongoing condition.

(8) To the extent that the plan permits a free choice of provider to its subscribers and enrollees, the statement shall disclose the nature and extent of choice permitted and the financial liability that is, or may be, incurred by the subscriber, enrollee, or a third party by reason of the exercise of that choice.

(9) A summary of the provisions required by subdivision (g) of Section 1373, if applicable.

(10) If the plan utilizes arbitration to settle disputes, a statement of that fact.

(11) A summary of, and a notice of the availability of, the process the plan uses to authorize, modify, or deny health care services under the benefits provided by the plan, pursuant to Sections 1363.5 and 1367.01.

(12) A description of any limitations on the patient's choice of primary care physician, specialty care physician, or nonphysician health care practitioner, based on service area and limitations on the patient's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

(13) General authorization requirements for referral by a primary care physician to a specialty care physician or a nonphysician health care practitioner.

(14) Conditions and procedures for disenrollment.

(15) A description as to how an enrollee may request continuity of care as required by Section 1373.96 and request a second opinion pursuant to Section 1383.15.

(16) Information concerning the right of an enrollee to request an independent review in accordance with Article 5.55 (commencing with Section 1374.30).

(17) A notice as required by Section 1364.5.

(c) (1) As of July 1, 1999, the director shall require each plan offering a contract to an individual or small group to provide with the disclosure form for individual and small group plan contracts a uniform health plan benefits and coverage matrix containing the plan's major provisions in order to facilitate comparisons between plan contracts. The uniform matrix shall include the following category descriptions together with the corresponding copayments and limitations in the following sequence:

(A) Deductibles.

(B) Lifetime maximums.

(C) Professional services.

(D) Outpatient services.

(E) Hospitalization services.

(F) Emergency health coverage.

(G) Ambulance services.

(H) Prescription drug coverage.

(I) Durable medical equipment.

(J) Mental health services.

(K) Chemical dependency services.

(L) Home health services.

(M) Other.

(2) The following statement shall be placed at the top of the matrix in all capital letters in at least 10-point boldface type:

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

(3) (A) A health care service plan contract subject to Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15), shall satisfy the requirements of this subdivision by providing the uniform summary of benefits and coverage required under Section 2715 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-15) and any rules or regulations issued thereunder. A health care service plan that issues the uniform summary of benefits referenced in this paragraph shall do both of the following:

(i) Ensure that all applicable benefit disclosure requirements specified in this chapter and in Title 28 of the California Code of Regulations are met in other health plan documents provided to enrollees under the provisions of this chapter.

(ii) Consistent with applicable law, advise applicants and enrollees, in a prominent place in the plan documents referenced in subdivision (a), that enrollees are not financially responsible in payment of emergency care services, in any amount that the health care service plan is obligated to pay, beyond the enrollee's copayments, coinsurance, and deductibles as provided in the enrollee's health care service plan contract.

(B) Commencing October 1, 2016, the uniform summary of benefits and coverage referenced in this paragraph shall constitute a vital document for the purposes of Section 1367.04. Not later than July 1, 2016, the department 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 department shall make available on its internet website written translations of the template uniform summary of benefits and coverage developed by the department, and written translations prepared by the United States Department of Labor, if available, for any language group to which this subparagraph applies.

(C) Subdivision (d) shall not apply to a health care service plan contract subject to subparagraph (A).

(4) A health care service plan may satisfy the requirements of this subdivision for the dental services offered under a contract subject to Section 1363.04 by providing the uniform benefit disclosure benefits and coverage disclosure matrix consistent with the requirements of that section.

(d) Nothing in this section shall prevent a plan from using appropriate footnotes or disclaimers to reasonably and fairly describe coverage arrangements in order to clarify any part of the matrix that may be unclear.

(e) All plans, solicitors, and representatives of a plan shall, when presenting any plan contract for examination or sale to an individual prospective plan member, provide the individual with a properly completed disclosure form, as prescribed by the director pursuant to this section for each plan so examined or sold.

(f) In the case of group contracts, the completed disclosure form and evidence of coverage shall be presented to the contractholder upon delivery of the completed health care service plan agreement.

(g) Group contractholders shall disseminate copies of the completed disclosure form to all persons eligible to be a subscriber under the group contract at the time those persons are offered the plan. If the individual group members are offered a choice of plans, separate disclosure forms shall be supplied for each plan available. Each group contractholder shall also disseminate or cause to be disseminated copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(h) In the case of conflicts between the group contract and the evidence of coverage, the provisions of the evidence of coverage shall be binding upon the plan notwithstanding any provisions in the group contract that may be less favorable to subscribers or enrollees.

(i) In addition to the other disclosures required by this section, every health care service plan and any agent or employee of the plan shall, when presenting a plan for examination or sale to any individual purchaser or the representative of a group consisting of 25 or fewer individuals, disclose in writing the ratio of premium costs to health services paid for plan contracts with individuals and with

groups of the same or similar size for the plan's preceding fiscal year. A plan may report that information by geographic area, provided the plan identifies the geographic area and reports information applicable to that geographic area.

(j) Subdivision (c) shall not apply to any coverage provided by a plan for the Medi-Cal program or the Medicare Program pursuant to Title XVIII and Title XIX of the federal Social Security Act.

(k) Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services pursuant to Chapter 7 (commencing with Section 14000) or Chapter 8 (commencing with Section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code shall not be required to use the standard templates developed by the department pursuant to this section.

(l) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of issuing and modifying templates and all-plan letters or similar instructions, without taking regulatory action.

(Amended by Stats. 2023, Ch. 42, Sec. 13. (AB 118) Effective July 10, 2023.)

1363.01. (a) Every plan that covers prescription drug benefits shall provide notice in the evidence of coverage and disclosure form to enrollees regarding whether the plan uses a formulary. The notice shall be in language that is easily understood and in a format that is easy to understand. The notice shall include an explanation of what a formulary is, how the plan determines which prescription drugs are included or excluded, and how often the plan reviews the contents of the formulary.

(b) Every plan that covers prescription drug benefits shall provide to members of the public, upon request, information regarding whether a specific drug or drugs are on the plan's formulary. Notice of the opportunity to secure this information from the plan, including the plan's telephone number for making a request of this nature and the Internet Web site where the formulary is posted under Section 1367.205, shall be included in the evidence of coverage and disclosure form to enrollees.

(c) Every plan shall notify enrollees, and members of the public who request formulary information, that the presence of a drug on the plan's formulary does not guarantee that an enrollee will be prescribed that drug by his or her prescribing provider for a particular medical condition.

(Amended by Stats. 2014, Ch. 575, Sec. 2. (SB 1052) Effective January 1, 2015.)

1363.02. (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, a health care service plan that covers hospital, medical, and surgical benefits 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 plan contract 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 enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the health plan at (insert the health plan'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 health plan's website, if any, and include this statement in a conspicuous place in the plan's evidence of coverage and disclosure forms.

(c) A health care service plan 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 specialized health care service plans or Medicare supplement plans.

(Added by Stats. 2000, Ch. 347, Sec. 2. Effective January 1, 2001.)

1363.03. (a) Every health care service plan that covers prescription drug benefits and that issues a card to enrollees for claims processing purposes shall issue to each of its enrollees a uniform card containing uniform prescription drug information. The uniform prescription drug information card shall, at a minimum, include the following information:

(1) The name or logo of the benefit administrator or health care service plan issuing the card, which shall be displayed on the front side of the card.

(2) The enrollee's identification number, or the subscriber's identification number when the enrollee is a dependent who accesses services using the subscriber's identification number, which shall be displayed on the front side of the card.

(3) A telephone number that pharmacy providers may call for assistance.

(4) Information required by the benefit administrator or health care service plan that is necessary to commence processing the pharmacy claim, except as provided for in paragraph (5).

(5) A health care service plan shall not be required to print any of the following information on a member card:

(A) Any number that is the same for all of its members, provided that the health care service plan provides this number to the pharmacy on an annual basis.

(B) Any information that may result in fraudulent use of the card.

(C) Any information that is otherwise prohibited from being included on the card.

(b) Beginning July 1, 2002, the new uniform prescription drug information card required by subdivision (a) shall be issued by a health care service plan to an enrollee upon enrollment or upon any change in the enrollee's coverage that impacts the data content or format of the card.

(c) Nothing in this section requires a health care service plan to issue a separate card for prescription drug coverage if the plan issues a card for health care coverage in general and the card is able to accommodate the information required by subdivision (a).

(d) This bill shall not apply to a nonprofit health care service plan with at least 3.5 million enrollees that owns or operates its own pharmacies and that provides health care services to enrollees in a specific geographic area through a mutually exclusive contract with a single medical group.

(e) "Card" as used in this section includes other technology that performs substantially the same function as a card.

(f) For purposes of this section, if a health care service plan delegates responsibility for issuing the uniform prescription drug information card to a contractor or agent, then the contract between the health care service plan and its contractor or agent shall require compliance with this section.

(Added by Stats. 2001, Ch. 622, Sec. 1. Effective January 1, 2002.)

1363.04. (a) For plan years on and after January 1, 2021, or 12 months after regulations are adopted under subdivision (f), whichever occurs later, a health care service plan that issues, sells, renews, or offers a contract that covers dental services in this state, in addition to any other applicable disclosure requirements, shall utilize a uniform benefits and coverage disclosure matrix, which shall be developed by the department, in conjunction with the Department of Insurance, and in consultation with stakeholders. At a minimum, the benefits and coverage disclosure matrix shall require the health care service plan to make available all of the following information relating to covered dental services, together with the corresponding copayments or coinsurance and limitations:

(1) The annual overall plan 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 plan reimbursement levels and estimated enrollee cost share for services.

(5) Waiting periods.

(6) Examples to illustrate coverage and estimated enrollee 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 plans, solicitors, and representatives of a plan that issue, sell, renew, or offer a health care plan contract that covers dental services shall, when presenting any plan contract for examination or sale to an individual prospective plan member, make available to the individual a properly completed benefits and coverage disclosure matrix, as prescribed by the director pursuant to this section for each dental plan examined or sold.

(c) In the case of group contracts for dental services, the completed benefits and coverage disclosure matrix and evidence of coverage shall be made available to the contractholder upon delivery of the completed health care service plan agreement.

(d) Group contractholders shall make available the completed benefits and coverage disclosure matrix to all persons eligible to be a subscriber under the group contract at the time those persons are offered the dental plan. If the individual group members are offered a choice of dental plans, separate matrices shall be made available for each dental plan offered. Each group contractholder shall also make available copies of the evidence of coverage to all applicants, upon request, prior to enrollment and to all subscribers enrolled under the group contract.

(e) The health care service plan offering a dental product 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 enrollees 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 Insurance 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. 2. (SB 1008) Effective January 1, 2019.)

1363.05. (a) For every plan contract that provides or supplements Medicare benefits, a plan shall include within its disclosure form the following statement in at least 12-point type:

"For additional information concerning covered benefits, contact the Health Insurance Counseling and Advocacy Program (HICAP) or your agent. HICAP provides health insurance counseling for California senior citizens. Call the HICAP toll-free telephone number, 1-800-434-0222, for a referral to your local HICAP office. HICAP is a service provided free of charge by the State of California."

(b) For every plan contract that provides or supplements Medicare benefits, a plan shall modify its disclosure forms to comply with subdivision (a) no later than January 1, 1998.

(c) Every health care service plan that provides or supplements Medicare benefits shall notify those current enrollees who enrolled prior to the modification of disclosure forms to include the disclosure statement required by subdivision (a) of the availability of the HICAP program. That notification shall include the same language as is required by subdivision (a). That notification may be by free standing document and shall be made no later than January 1, 1998.

(Added by Stats. 1996, Ch. 1113, Sec. 1. Effective January 1, 1997.)

1363.06. (a) The Department of Managed Health Care and the Department of Insurance shall compile information as required by this section and Section 10127.14 of the Insurance Code into two comparative benefit matrices. The first matrix shall compare benefit packages offered pursuant to Section 1373.62 and Section 10127.15 of the Insurance Code. The second matrix shall compare benefit packages offered pursuant to Sections 1366.35, 1373.6, and 1399.804 and Sections 10785, 10901.2, and 12682.1 of the Insurance Code.

(b) The comparative benefit matrix shall include:

(1) Benefit information submitted by health care service plans pursuant to subdivision (d) and by health insurers pursuant to Section 10127.14 of the Insurance Code.

(2) The following statements in at least 12-point type at the top of the matrix:

(A) "This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, please contact the health care service plan or health insurer."

(B) "The comparative benefit summary is updated annually, or more often if necessary to be accurate."

(C) "The most current version of this comparative benefit summary is available on (address of the plan's or insurer's Internet Web site)."

This subparagraph applies only to those plans or insurers that maintain an Internet Web site.

(3) The telephone number or numbers that may be used by an applicant to contact either the department or the Department of Insurance, as appropriate, for further assistance.

(c) The Department of Managed Health Care and the Department of Insurance shall jointly prepare two standardized templates for use by health care service plans and health insurers in submitting the information required pursuant to subdivision (d) and subdivision (d) of Section 10127.14 of the Insurance Code. The templates shall be exempt from the provisions of Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code.

(d) Health care service plans, except specialized health care service plans, shall submit the following to the department by January 31, 2003, and annually thereafter:

(1) A summary explanation of the following for each product described in subdivision (a).

(A) Eligibility requirements.

(B) The full premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside.

(C) When and under what circumstances benefits cease.

(D) The terms under which coverage may be renewed.

(E) Other coverage that may be available if benefits under the described benefit package cease.

(F) The circumstances under which choice in the selection of physicians and providers is permitted.

(G) Lifetime and annual maximums.

(H) Deductibles.

(2) A summary explanation of coverage for the following, together with the corresponding copayments and limitations, for each product described in subdivision (a):

(A) Professional services.

(B) Outpatient services.

(C) Hospitalization services.

(D) Emergency health coverage.

(E) Ambulance services.

(F) Prescription drug coverage.

(G) Durable medical equipment.

(H) Mental health services.

(I) Residential treatment.

(J) Chemical dependency services.

(K) Home health services.

(L) Custodial care and skilled nursing facilities.

(3) The telephone number or numbers that may be used by an applicant to access a health care service plan customer service representative and to request additional information about the plan contract.

(4) Any other information specified by the department in the template.

(e) Each health care service plan shall provide the department with updates to the information required by subdivision (d) at least annually, or more often if necessary to maintain the accuracy of the information.

(f) The department and the Department of Insurance shall make the comparative benefit matrices available on their respective Internet Web sites and to the health care service plans and health insurers for dissemination as required by Section 1373.6 and Section 12682.1 of the Insurance Code, after confirming the accuracy of the description of the matrices with the health care service plans and health insurers.

(g) As used in this section and Section 1363.07, "benefit matrix" shall have the same meaning as benefit summary.

(h) (1) This section shall be inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative on the date of that repeal or amendment.

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

(Amended by Stats. 2013, Ch. 441, Sec. 1. (AB 1180) Effective October 1, 2013. Inoperative, by its own provisions, on January 1, 2014, subject to condition for resuming operation.)

1363.07. (a) Each health care service plan shall send copies of the comparative benefit matrix prepared pursuant to Section 1363.06 on an annual basis, or more frequently as the matrix is updated by the department and the Department of Insurance, to solicitors and solicitor firms and employers with whom the plan contracts.

(b) Each health care service plan shall require its representatives and solicitors and soliciting firms with which it contracts, to provide a copy of the comparative benefit matrix to individuals when presenting any benefit package for examination or sale.

(c) Each health care service plan that maintains an Internet Web site shall make a downloadable copy of the comparative benefit matrix described in Section 1363.06 available through a link on its site to the Internet Web sites of the department and the Department of Insurance.

(d) (1) This section shall be inoperative on January 1, 2014.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of PPACA, is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Sec. 300gg-91), this section shall become operative on the date of that repeal or amendment.

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

(Amended by Stats. 2013, Ch. 441, Sec. 2. (AB 1180) Effective October 1, 2013. Inoperative, by its own provisions, on January 1, 2014, subject to condition for resuming operation.)

1363.1. Any health care service plan that includes terms that require binding arbitration to settle disputes and that restrict, or provide for a waiver of, the right to a jury trial shall include, in clear and understandable language, a disclosure that meets all of the following conditions:

(a) The disclosure shall clearly state whether the plan uses binding arbitration to settle disputes, including specifically whether the plan uses binding arbitration to settle claims of medical malpractice.

(b) The disclosure shall appear as a separate article in the agreement issued to the employer group or individual subscriber and shall be prominently displayed on the enrollment form signed by each subscriber or enrollee.

(c) The disclosure shall clearly state whether the subscriber or enrollee is waiving his or her right to a jury trial for medical malpractice, other disputes relating to the delivery of service under the plan, or both, and shall be substantially expressed in the wording provided in subdivision (a) of Section 1295 of the Code of Civil Procedure.

(d) In any contract or enrollment agreement for a health care service plan, the disclosure required by this section shall be displayed immediately before the signature line provided for the representative of the group contracting with a health care service plan and immediately before the signature line provided for the individual enrolling in the health care service plan.

(Added by Stats. 1994, Ch. 653, Sec. 3. Effective January 1, 1995.)

1363.2. On or before July 1, 1999, the disclosure form required pursuant to Section 1363 shall also contain a statement that enrollees are encouraged to use appropriately the "911" emergency response system, in areas where the system is established and operating, when they have an emergency medical condition that requires an emergency response.

(Added by Stats. 1998, Ch. 979, Sec. 2. Effective January 1, 1999.)

1363.3. (a) The department may develop standard templates for a schedule of benefits, an explanation of benefits, a cost-sharing summary, or any similar document. The standard template or templates may include standard definitions, notice and explanatory language, benefit and limitation descriptions, and any other information or formatting in the template that the director determines would provide the public, subscribers, and enrollees with a full and fair disclosure of the provisions of the plan in readily understood language and in a clearly organized manner. The department shall consult with the Department of Insurance and interested stakeholders in developing standard templates under this section.

(b) The department may require health care service plans to utilize the standard templates developed by the department pursuant to subdivision (a) for any schedule of benefits, explanation of benefits, cost-sharing summaries, or similar documents published or distributed.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of issuing and modifying templates and all-plan letters or similar instructions, without taking regulatory action.

(d) The director may require a health care service plan to file any document the health care service plan developed using a standard template developed by the department for compliance review.

(Added by Stats. 2023, Ch. 42, Sec. 14. (AB 118) Effective July 10, 2023.)

1363.5. (a) A plan shall disclose or provide for the disclosure to the director and to network providers the process the plan, its contracting provider groups, or any entity with which the plan contracts for services that include utilization review or utilization management functions, uses to authorize, modify, or deny health care services under the benefits provided by the plan, including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. A plan shall also disclose those processes to enrollees or persons designated by an enrollee, or to any other person or organization, upon request. The disclosure to the director shall include the policies, procedures, and the description of the process that are filed with the director pursuant to subdivision (b) of Section 1367.01.

(b) The criteria or guidelines used by plans, or any entities with which plans contract for services that include utilization review or utilization management functions, to determine whether to authorize, modify, or deny health care services shall:

(1) Be developed with involvement from actively practicing health care providers.

(2) Be consistent with sound clinical principles and processes.

(3) Be evaluated, and updated if necessary, at least annually.

(4) If used as the basis of a decision to modify, delay, or deny services in a specified case under review, be disclosed to the provider and the enrollee in that specified case.

(5) Be available to the public upon request. A plan shall only be required to disclose the criteria or guidelines for the specific procedures or conditions requested. A plan may charge reasonable fees to cover administrative expenses related to disclosing criteria or guidelines pursuant to this paragraph, limited to copying and postage costs. The plan may also make the criteria or guidelines available through electronic communication means.

(c) The disclosure required by paragraph (5) of subdivision (b) shall be accompanied by the following notice: "The materials provided to you are guidelines used by this plan to authorize, modify, or deny care for persons with similar illnesses or conditions. Specific care and treatment may vary depending on individual need and the benefits covered under your contract."

(Amended by Stats. 2000, Ch. 1067, Sec. 6. Effective January 1, 2001.)

1364. Where the director finds it necessary in the interest of full and fair disclosure, all advertising and other consumer information disseminated by a plan for the purpose of influencing persons to become members of a plan shall contain such supplemental disclosure information as the director may require.

(Amended by Stats. 1999, Ch. 525, Sec. 90. Effective January 1, 2000. Operative July 1, 2000, or sooner, by Sec. 214 of Ch. 525.)

1364.1. Within 30 days of receiving the notice required by Section 1255.1, a health care service plan shall notify, or provide for the notification of, enrollees who have selected a medical group or independent practice association that uses a hospital that the

hospital will reduce or eliminate its emergency services. The plan may require that its contracting medical groups and independent practice associations that use the hospital provide this notice. The notice shall include a list of alternate hospitals that may be used by enrollees for emergency services.

(Added by Stats. 1998, Ch. 995, Sec. 5. Effective January 1, 1999.)

1364.5. (a) On or before July 1, 2001, every health care service plan shall file with the director a copy of their policies and procedures to protect the security of patient medical information to ensure compliance with the Confidentiality of Information Act (Part 2.6 (commencing with Section 56) of Division 1 of the Civil Code). Any amendment to the policies and procedures shall be filed in accordance with Section 1352.

(b) On and after July 1, 2001, every health care service plan shall, upon request, provide to enrollees and subscribers a written statement that describes how the contracting organization or health care service plan maintains the confidentiality of medical information obtained by and in the possession of the contracting organization or the health care service plan.

(c) The statement required by subdivision (b) shall be in at least 12-point type and meet the following requirements:

(1) The statement shall describe how the contracting organization or health care service plan protects the confidentiality of medical information pursuant to this article and inform patients or enrollees and subscribers that any disclosure of medical information beyond the provisions of the law is prohibited.

(2) The statement shall describe the types of medical information that may be collected and the type of sources that may be used to collect the information, the purposes for which the contracting organization or plan will obtain medical information from other health care providers.

(3) The statement shall describe the circumstances under which medical information may be disclosed without prior authorization, pursuant to Section 56.10 of the Civil Code.

(4) The statement shall describe how patients or enrollees and subscribers may obtain access to medical information created by and in the possession of the contracting organization or health care service plan, including copies of medical information.

(d) On and after July 1, 2001, every health care service plan shall include in its evidence of coverage or disclosure form the following notice, in 12-point type:

A STATEMENT DESCRIBING (NAME OR PLAN OR "OUR") POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

(Amended by Stats. 2000, Ch. 1067, Sec. 7. Effective January 1, 2001.)

1365. (a) An enrollment or a subscription shall not be canceled or not renewed except for the following reasons:

(1) (A) Except as otherwise specified in subparagraph (C), for nonpayment of the required premiums by the individual, employer, or contractholder if the individual, employer, or contractholder has been duly notified and billed for the charge 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.

(B) Pursuant to subparagraph (A), a health care service plan shall continue to provide coverage as required by the individual's, employer's, or contractholder's health care service plan contract during the 30-day period described in subparagraph (A).

(C) (i) 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.

(ii) During the first month of the three-month grace period described in clause (i), a health care service plan 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 enrollee.

(II) Provide coverage as required by the individual's health care service plan contract.

(iii) If the individual exhausts the three-month grace period described in clause (i) without paying all outstanding premiums due, the health care service plan 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 clause (i), 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 clause (i), pursuant to subdivision (a) of Section 100805 of the Government Code.

(iv) A health care service plan 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 care service plan 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 advanced premium assistance subsidy authorized by Section 100800 of the Government Code.

(2) The plan demonstrates fraud or an intentional misrepresentation of material fact under the terms of the health care service plan contract by the individual contractholder or employer.

(3) In the case of an individual health care service plan contract, the individual subscriber no longer resides, lives, or works in the plan's service area, but only if the coverage is terminated uniformly without regard to any health status-related factor of covered individuals.

(4) In the case of a group health care service plan contract, violation of a material contract provision relating to employer contribution or group participation rates by the contractholder or employer.

(5) If the plan ceases to provide or arrange for the provision of health benefits for new health care service plan contracts in the individual or group market, or all markets, in this state, provided, however, that the following conditions are satisfied:

(A) Notice of the decision to cease new or existing health benefit plans in the state is provided to the director, the individual or group contractholder or employer, and the enrollees covered under those contracts, at least 180 days prior to discontinuation of those contracts.

(B) Health benefit plans shall not be canceled for 180 days after the date of the notice required under subparagraph (A) and, for that business of a plan that remains in force, any plan that ceases to offer for sale new health benefit plans shall continue to be governed by this section with respect to business conducted under this section.

(C) Except as authorized under subdivision (b) of Section 1357.09 and Section 1357.10, a plan that ceases to write new health benefit plans in the individual or group market, or all markets, in this state shall be prohibited from offering for sale health benefit plans in that market or markets in this state for a period of five years from the date of the discontinuation of the last coverage not so renewed.

(6) If the plan withdraws a health benefit plan from the market, provided that all of the following conditions are satisfied:

(A) The plan notifies all affected subscribers, contractholders, employers, and enrollees and the director at least 90 days prior to the discontinuation of the plan.

(B) The plan makes available to the individual or group contractholder or employer all health benefit plans that it makes available to new individual or group business, respectively.

(C) In exercising the option to discontinue a health benefit plan under this paragraph and in offering the option of coverage under subparagraph (B), the plan acts uniformly without regard to the claims experience of the individual or contractholder or employer, or any health status-related factor relating to enrollees or potential enrollees.

(D) For small employer health care service plan contracts offered under Article 3.1 (commencing with Section 1357), the premium for the new plan contract complies with the renewal increase requirements set forth in Section 1357.12. This subparagraph shall not apply after December 31, 2013.

(7) In the case of a group health benefit plan, if an individual or employer ceases to be a member of a guaranteed association, as defined in subdivision (n) of Section 1357, but only if that coverage is terminated under this paragraph uniformly without regard to

any health status-related factor relating to any enrollee.

(b) (1) An enrollee or subscriber who alleges that an enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed may request a review by the director pursuant to Section 1368.

(2) If the director determines that a proper complaint exists, the director shall notify the plan and the enrollee or subscriber who requested the review.

(3) If, after review, the director determines that the cancellation, rescission, or failure to renew is contrary to existing law, the director shall order the plan to reinstate the enrollee or subscriber. Within 15 days after receipt of that order, the health care service plan shall request a hearing or reinstate the enrollee or subscriber.

(4) If an enrollee or subscriber requests a review of the health care service plan's determination to cancel or rescind or failure to renew the enrollee's or subscriber's health care service plan contract pursuant to this section, the health care service plan shall continue to provide coverage to the enrollee or subscriber under the terms of the contract until a final determination of the enrollee's or subscriber's request for review has been made by the director. This paragraph shall not apply if the health care service plan cancels or does not renew the enrollee's or subscriber's health care service plan contract for nonpayment of premiums pursuant to paragraph (1) of subdivision (a).

(5) A reinstatement pursuant to this subdivision shall be retroactive to the time of cancellation, rescission, or failure to renew and the plan shall be liable for the expenses incurred by the subscriber or enrollee for covered health care services from the date of cancellation, rescission, or nonrenewal to and including the date of reinstatement. The health care service plan shall reimburse the enrollee or subscriber for any expenses incurred pursuant to this paragraph within 30 days of receipt of the completed claim.

(c) This section shall not abrogate any preexisting contracts entered into prior to the effective date of this chapter between a subscriber or enrollee and a health care service plan or a specialized health care service plan, including, but not limited to, the financial liability of the plan, except that each plan shall, if directed to do so by the director, exercise its authority, if any, under those preexisting contracts to conform them to existing law.

(d) As used in this section, "health benefit plan" means any individual or group insurance policy or health care service plan contract that provides medical, hospital, and surgical benefits. The term does not include accident only, credit, or disability income coverage, coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, long-term care insurance, dental or vision coverage, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation law or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(e) On or before July 1, 2011, the director may issue guidance to health care service plans regarding compliance with this section and that guidance shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). Any guidance issued pursuant to this subdivision shall only be effective through December 31, 2013, or until the director adopts and effects regulations pursuant to the Administrative Procedure Act, whichever occurs first.

(Amended by Stats. 2019, Ch. 38, Sec. 15. (SB 78) Effective June 27, 2019.)

1365.5. (a) No health care service plan or specialized health care service plan shall refuse to enter into any contract or shall cancel or decline to renew or reinstate any contract because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, prospective contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise.

(b) The terms of any contract shall not be modified, and the benefits or coverage of any contract shall not be subject to any limitations, exceptions, exclusions, reductions, copayments, coinsurance, deductibles, reservations, or premium, price, or charge differentials, or other modifications because of the race, color, national origin, ancestry, religion, sex, marital status, sexual orientation, or age of any contracting party, potential contracting party, or person reasonably expected to benefit from that contract as a subscriber, enrollee, member, or otherwise; except that premium, price, or charge differentials because of the age of any individual when based on objective, valid, and up-to-date statistical and actuarial data are not prohibited.

(c) It shall be deemed a violation of subdivision (a) for any health care service plan to utilize marital status, living arrangements, occupation, sex, beneficiary designation, ZIP Codes or other territorial classification, or any combination thereof for the purpose of establishing sexual orientation. Nothing in this section shall be construed to alter in any manner the existing law prohibiting health care service plans from conducting tests for the presence of human immunodeficiency virus or evidence thereof.

(d) This section shall not be construed to limit the authority of the director to adopt or enforce regulations prohibiting discrimination because of sex, marital status, or sexual orientation.

(e) "Sex" as used in this section shall have the same meaning as "gender," as defined in Section 422.56 of the Penal Code.

(f) The changes made to this section by the act adding this subdivision shall only apply to contracts issued, amended, or renewed on or after January 1, 2011.

(Amended by Stats. 2009, Ch. 365, Sec. 1. (AB 119) Effective January 1, 2010.)

1366. (a) No plan may use in its name, any of the words "insurance," "casualty," "surety," "mutual," or any other words descriptive of the insurance, casualty, or surety business or use any name similar to the name or description of any insurance or surety corporation doing business in this state unless such plan controls or is controlled by an entity licensed as an insurer pursuant to the provisions of the Insurance Code and the plan employs a name related to that of such controlled or controlling entity.

(b) Section 2415 of the Business and Professions Code, pertaining to fictitious names, shall not apply to plans, except specialized health care service plans.

(c) No plan or solicitor firm may adopt a name style that is deceptive, or one that could cause the public to believe the plan is affiliated with, or recommended by any governmental or private entity unless such affiliation or endorsement exists.

(Amended by Stats. 1980, Ch. 1313.)

1366.1. (a) The department shall adopt regulations on or before July 1, 2003, that establish an extended geographic accessibility standard for access to health care providers served by a health care service plan in counties with a population of 500,000 or less, and that, as of January 1, 2002, have two or fewer health care service plans providing coverage to the entire county in the commercial market.

(b) This section shall not apply to specialized health care service plans or health care service plan contracts that provide benefits to enrollees through any of the following:

(1) Preferred provider contracting arrangements.

(2) The Medi-Cal program.

(3) The Healthy Families program.

(c) (1) At least 30 days before a health care service plan files for modification of its license with the department in order to withdraw from a county with a population of 500,000 or less, or a portion of that county, the health care service plan shall hold a public meeting in the county or portion of the county from which it intends to withdraw, and shall do all of the following:

(A) Provide notice announcing the public meeting at least 30 days prior to the public meeting to all affected enrollees, health care providers, advocates, public officials, and other interested parties.

(B) Provide notice announcing the public meeting at least 30 days prior to the public meeting in a newspaper of general circulation within the affected county or portion of the affected county.

(C) At the public meeting, allow testimony, which may be limited to a certain length of time by the health care service plan, of all interested parties.

(D) Send a summary of the comments received at the public meeting to the department.

(E) Send a summary of the comments received at the public meeting to the Centers for Medicare and Medicaid Services if the modification would affect Medicare beneficiaries.

(F) File with the department for review, no less than 30 days prior to the date of mailing or publication, the notices required under subparagraphs (A) and (B).

(2) A representative of the department shall attend the public meeting.

(Added by Stats. 2002, Ch. 549, Sec. 1. Effective January 1, 2003. See somewhat similar section added by Stats. 2002, Ch. 928, which prevails to the extent of any conflicting provisions.)

1366.1. (a) The department shall adopt regulations on or before July 1, 2003, that establish an extended geographic accessibility standard for access to health care providers served by a health care service plan in counties with a population of 500,000 or less, and that, as of January 1, 2002, have two or fewer health care service plans providing coverage to the entire county in the commercial market.

(b) This section shall not apply to specialized health care service plans or health care service plan contracts that provide benefits to enrollees through any of the following:

- (1) Preferred provider contracting arrangements.
- (2) The Medi-Cal program.
- (3) The Healthy Families Program.
- (4) The federal Medicare program.

(c) At least 30 days before a health care service plan files a notice of material modification of its license with the department to withdraw from a county with a population of 500,000 or less, the health care service plan shall hold a public meeting in the county from which it is intending to withdraw, and shall do all of the following:

- (1) Provide notice announcing the public meeting at least 30 days prior to the public meeting to all affected enrollees, health care providers with which it contracts, the members of the board of supervisors of the affected county, the members of the city councils of cities in the affected county, and members of the Legislature who represent the affected county.
- (2) Provide notice announcing the public meeting at least 15 days prior to the public meeting in a newspaper of general circulation within the affected county.
- (3) At the public meeting, allow testimony, which may be limited to a certain length of time by the health care service plan, of all interested parties.
- (4) File with the department for review, no less than 30 days prior to the date of mailing or publication, the notices required under paragraphs (1) and (2).

(d) The department may require a health care service plan that has filed to withdraw from a portion of a county with a population of less than 500,000, to hold a hearing for affected enrollees.

(e) A representative of the department shall attend the public meeting described in this section.

(Added by Stats. 2002, Ch. 928, Sec. 1. Effective January 1, 2003. See somewhat similar section added by Stats. 2002, Ch. 549.)

1366.2. (a) A full health care service plan shall make available to a group subscriber, upon request, the termination date of all major health care provider contracts that are for services in the geographic area for which the group subscriber has secured coverage and that include a specified termination date.

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

- (1) "Enrollee" means a person who is enrolled in a health care service plan and who is a recipient of services from the plan.
- (2) "Full health care service plan" means a plan that meets the definition set forth in subdivision (f) of Section 1345, and that has a total enrolled membership exceeding 499,999 enrollees.
- (3) "Hospital" means a general acute care hospital.
- (4) "Major health care provider contract" means a contract between a full service plan and provider group or hospital covering more than 25,000 of that plan's enrollees. "Major health care provider contract" does not mean a provider contract between a specialized health care service plan and a provider group or hospital.
- (5) "Provider group" means a medical group, independent practice association, or other similar group of providers with a total enrolled membership exceeding 99,999 enrollees.

(Added by Stats. 2004, Ch. 411, Sec. 1. Effective September 9, 2004.)

1366.3. (a) On and after January 1, 2005, a health care service plan issuing individual plan contracts that ceases to offer individual coverage in this state shall offer coverage to the subscribers who had been covered by those contracts at the time of withdrawal under the same terms and conditions as provided in paragraph (3) of subdivision (a), paragraphs (2) to (4), inclusive, of subdivision (b), subdivisions (c) to (e), inclusive, and subdivision (h) of Section 1373.6.

(b) A health care service plan that ceases to offer individual coverage in a service area shall offer the coverage required by subdivision (a) to subscribers who had been covered by those contracts at the time of withdrawal, if the plan continues to offer group coverage in that service area. This subdivision shall not apply to coverage provided pursuant to a preferred provider organization.

(c) The department may adopt regulations to implement this section.

(d) This section shall not apply when a plan participating in Medi-Cal, Healthy Families, Access for Infants and Mothers, or any other contract between the plan and a government entity no longer contracts with the government entity to provide health coverage in the state, or a specified area of the state, nor shall this section apply when a plan ceases entirely to market, offer, and issue any and all forms of coverage in any part of this state after the effective date of this section.

(e) (1) On and after January 1, 2014, and except as provided in paragraph (2), the reference to Section 1373.6 in subdivision (a) shall not apply to any health plan contracts.

(2) If Section 5000A of the Internal Revenue Code, as added by Section 1501 of 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), is repealed or amended to no longer apply to the individual market, as defined in Section 2791 of the federal Public Health Service Act (42 U.S.C. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment.

(Amended by Stats. 2013, Ch. 441, Sec. 3. (AB 1180) Effective October 1, 2013.)

1366.4. (a) A medical group, physician, or independent practice association that contracts with a health care service plan may enter into contracts with licensed nonphysician providers to provide services, as defined in Section 1300.67(a)(1) of Title 28 of the California Code of Regulations, to plan enrollees covered by the contract between the plan and the group, physician, or association.

(b) The licensed nonphysician provider described in subdivision (a) that contracts with a medical group, physician, or independent practice association may directly bill, if direct billing is otherwise permitted by law, a health care service plan for covered services pursuant to a contract with the health care service plan that specifies direct billing. Direct billing pursuant to this subdivision is permitted only to the extent that the same services are not billed for by the medical group, physician, or independent practice association.

(c) A health care service plan may require the nonphysician provider to complete an appropriate credentialing process.

(d) Every health care service plan may either list licensed nonphysician providers that contract with medical groups, physicians, and independent practice associations pursuant to subdivision (b) in any listing or directory of plan health care providers that is provided to enrollees or to the public, or may include a notification in the plan's evidence of coverage or provider list that the health care service plan has contracts with nonphysician providers, pursuant to subdivision (b), and may list the types of contracted nonphysician providers. The notification may inform an enrollee that he or she may obtain a list of the nonphysician providers by contacting his or her primary or specialist medical group. The listing may indicate whether licensed nonphysician providers may be accessed directly by enrollees.

(e) Nothing in this section shall be construed to authorize, or otherwise require the director to approve, a risk-sharing arrangement between a plan and a provider.

(Amended by Stats. 2009, Ch. 298, Sec. 4. (AB 1540) Effective January 1, 2010.)

1366.6. (a) For purposes of this section, the following definitions shall apply:

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

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

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

(4) "Small employer" has the same meaning as that term is defined in Section 1357.500.

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

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

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

(4) This subdivision shall not apply to a bridge plan product that meets the requirements of Section 100504.5 of the Government Code to the extent approved by the appropriate federal agency.

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

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

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

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

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

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

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

(f) For purposes of this section, a bridge plan product shall mean an individual health benefit plan, as defined in subdivision (f) of Section 1399.845, that is offered by a health care service plan licensed under this chapter that contracts with the Exchange pursuant to Title 22 (commencing with Section 100500) of the Government Code.

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

(Amended (as amended by Stats. 2013, 1st Ex. Sess., Ch. 5, Sec. 8) by Stats. 2014, Ch. 572, Sec. 5. (SB 959) Effective January 1, 2015.

Conditionally inoperative, on date prescribed by its own provisions. Repealed, by its own provisions, on second January 1 after inoperative date. See later operative version, as amended by Sec. 6 of Stats. 2014, Ch. 572.)

1366.6. (a) For purposes of this section, the following definitions shall apply:

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

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

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

(4) "Small employer" has the same meaning as that term is defined in Section 1357.500.

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

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

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

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

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

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

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

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

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

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

(f) This section shall become operative only if Section 8 of the act that added this section becomes inoperative pursuant to subdivision (g) of that Section 8.

(Amended (as added by Stats. 2013, 1st Ex. Sess., Ch. 5, Sec. 9) by Stats. 2014, Ch. 572, Sec. 6. (SB 959) Effective January 1, 2015. Section conditionally operative by its own provisions.)