



Home	Bill Information	California Law	Publications	Other Resources	My Subscriptions	My Favorites
------	------------------	----------------	--------------	-----------------	------------------	--------------

Code: Section:

[Up^](#) [Add To My Favorites](#)

INSURANCE CODE - INS

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

PART 6.1. HEALTH DISABILITY INSURANCE CONVERSION [12670 - 12692.5] (Part 6.1 added by Stats. 1981, Ch. 1096, Sec. 2.)

12670. It is the intent of the Legislature to ensure that persons covered by a group policy, who become ineligible for that coverage have access to benefits pursuant to this part by requiring employers, employee organizations, and other entities that provide that coverage to their employees or members to also make available conversion policies for those persons and to ensure that insurers as herein defined offer conversion policies. The conversion policy shall be the most popular preferred provider organization product offered to residents of this state under the provisions of the federal Health Insurance Portability and Accountability Act of 1996. In addition, it is the intent of the Legislature to encourage the continuation of group health coverage by requiring the entities herein defined to make available continuation benefits for widows, widowers, divorced spouses, and dependents who were covered by the group policy on the date of termination of coverage.

(Amended by Stats. 2002, Ch. 799, Sec. 1. Effective January 1, 2003. Operative September 1, 2003, by Sec. 5 of Ch. 799.)

12671. As used in this part, the following terms have the following meanings:

- (a) "Group policy" means a group health insurance policy providing medical, hospital, surgical, major medical, or comprehensive medical coverage issued by an insurer, a group contract issued by a hospital service corporation, or medical, hospital, surgical, major medical, or comprehensive medical coverage otherwise provided by a policyholder to its employees or members, except for self-insurance programs provided by employers that are not exempt from the federal Employee Retirement Income Security Act of 1974 (ERISA), as specified in subdivision (i). For the purposes of this part, a group policy not having an established annual renewal date shall be considered renewed on each anniversary of its effective date.
- (b) "Conversion coverage" means health insurance benefits providing hospital, surgical, major medical, or comprehensive medical coverage issued to an individual under a converted policy.
- (c) "Converted policy" means a policy or contract providing conversion coverage issued by an insurance company or by a hospital service corporation, or individual hospital, surgical, major medical, or comprehensive medical coverage otherwise provided by a policyholder to its employees or members.
- (d) "Insurer" means the entity issuing a group policy, an individual or converted policy, a hospital service contract or an employer or employee organization otherwise providing medical, hospital, surgical, major medical, or comprehensive medical coverage to its employees or members.
- (e) "Insurance" refers to health insurance, major medical, or comprehensive coverage paid by premium or contribution under a group policy, a hospital service contract, or as otherwise provided by a policyholder to its employees or members other than by self-insuring except in the case of a plan that is exempt from ERISA, but does include an employer plan that is exempt from ERISA as specified in subdivision (i). "Insurance" does not include any of the following:
 - (1) Coverage provided solely as an accrued liability or by reason of a disability extension.
 - (2) Medicare supplement insurance.
 - (3) Vision-only insurance.
 - (4) Dental-only insurance.
 - (5) CHAMPUS supplement insurance.

(6) Hospital indemnity insurance.

(7) Accident-only insurance.

(8) Short-term limited duration health insurance. "Short-term limited duration health insurance" means health insurance coverage provided pursuant to a health insurance policy that has an expiration date specified in the policy that is less than 12 months after the original effective date of the coverage.

(9) Specified disease insurance that does not pay benefits on a fixed benefit, cash payment only basis.

(f) "Policyholder" means the holder of a group policy issued by an insurer, a holder of a group contract issued by a hospital service corporation or an employer, employee association, or other entity otherwise providing medical, hospital, surgical, major medical, or comprehensive medical coverage on a group basis to its employees or members.

(g) "Premium" means contribution or other consideration paid or payable for coverage under a group policy or converted policy.

(h) "Medicare" means Title XVIII of the United States Social Security Act as added by the Social Security Amendments of 1965 or as later amended or superseded.

(i) "Employer plan that is exempt from ERISA" means an employer plan that, pursuant to Section 1003 of Title 29 of the United States Code, is not covered by or that is exempt from Subchapter I (commencing with Section 1001) of Chapter 18 of Title 29 of the United States Code, except that, in the case of a governmental plan, it only includes a self-insured governmental plan as defined in subdivision (j).

(j) "Self-insured governmental plan" means a self-insured plan established or maintained for its employees by a public entity, as defined in Section 811.2 of the Government Code, that is a governmental plan as defined in subdivision (32) of Section 1002 of Title 29 of the United States Code.

(Amended by Stats. 2018, Ch. 687, Sec. 13. (SB 910) Effective January 1, 2019.)

12672. (a) Any group policy issued, amended, or renewed in this state on or after January 1, 1983, which provides insurance for employees or members on an expense-incurred or service basis, other than for a specific disease or for accidental injuries only, shall contain a provision that an employee or member whose coverage under the group policy has been terminated for any reason except as provided in this part, shall be entitled to have a converted policy issued to him or her by the insurer under whose group policy he or she was covered, without evidence of insurability, subject to the terms and conditions of this part.

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

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

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

(Amended by Stats. 2013, Ch. 441, Sec. 23. (AB 1180) Effective October 1, 2013. Inoperative, by its own provisions, on January 1, 2014, subject to condition for resuming operation.)

12673. Conversion coverage shall be required to be made available to an employee or member unless such coverage under the group policy terminates for one or more of the following reasons:

(a) The group policy or the policyholder's participation in the group policy terminates and the insurance is replaced by similar coverage under another group policy within 60 days of the date of termination of the group coverage or the policyholder's participation.

(b) The employee or member has failed to make any required payment of the premium or contribution when due.

(c) The employee or member had not been continuously covered during the three-month period immediately preceding the employee's or member's termination of coverage.

(Amended by Stats. 1982, Ch. 1186, Sec. 5.)

12674. A converted policy shall be issued effective on the day following the termination of coverage under the group policy if written application and the first premium payment for the conversion policy are made to the insurer not later than 31 days after the termination of insurance, unless such requirements are waived in writing by the insurer.

(Added by Stats. 1981, Ch. 1096, Sec. 2. Operative January 1, 1983, by Sec. 5 of Ch. 1096.)

12675. The premium for the conversion coverage shall be determined in accordance with the insurer's rates applicable to the age and class of risk of each person to be covered and to the type and amount of coverage provided.

(Added by Stats. 1981, Ch. 1096, Sec. 2. Operative January 1, 1983, by Sec. 5 of Ch. 1096.)

12676. The conversion coverage shall cover the employee or member and his or her dependents who were covered by the group policy on the date of termination of coverage. At the option of the insurer, a separate converted policy may be issued to cover any dependent.

(Added by Stats. 1981, Ch. 1096, Sec. 2. Operative January 1, 1983, by Sec. 5 of Ch. 1096.)

12677. The insurer shall not be required to issue a converted policy covering any person if such person is entitled to be covered by Medicare.

(Added by Stats. 1981, Ch. 1096, Sec. 2. Operative January 1, 1983, by Sec. 5 of Ch. 1096.)

12678. The insurer shall not be required to issue a converted policy covering any person if any of the following exists:

- (a) The person is covered for similar benefits by another individual policy.
- (b) The person is covered or is eligible to be covered for similar benefits by another group policy.
- (c) The person is covered or is eligible to be covered for similar benefits under any arrangement of coverage for persons in a group whether insured or uninsured.

(Amended by Stats. 2002, Ch. 799, Sec. 3. Effective January 1, 2003. Operative September 1, 2003, by Sec. 5 of Ch. 799.)

12679. A converted policy may provide that the insurer may at any time request information from any person covered thereunder as to whether he or she is covered for the similar benefits described in Section 12678. The converted policy shall provide that as of any premium due date the insurer may refuse to renew the policy or the coverage of any insured person for the following reasons only:

- (a) Failure of the individual covered by the converted policy to provide the requested information.
- (b) Fraud or material misrepresentation by the individual covered by the converted policy in applying for any benefits under the converted policy.
- (c) Eligibility of the individual covered by the converted policy for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy. As used in this section, "state or federal law" does not include 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, or Title XIX of the United States Social Security Act.
- (d) Nonpayment of premium.
- (e) Coverage of the individual for similar benefits under another individual policy.
- (f) Eligibility of the individual covered by the converted policy for coverage under any arrangement for coverage for persons in a group whether insured or uninsured.
- (g) Other reasons approved by the Insurance Commissioner.

(Amended by Stats. 1982, Ch. 1186, Sec. 7.5.)

12680. If conversion coverage is issued and benefits are also provided to a person under Section 12678, the insurer may limit the conversion benefits provided or available for such person so that such conversion benefits together with benefits provided or available from the sources referred to in Section 12678 shall not exceed 100 percent of the charges for covered benefits. Priority of any coverages involved shall be determined by the effective dates, the earlier one being first.

(Added by Stats. 1981, Ch. 1096, Sec. 2. Operative January 1, 1983, by Sec. 5 of Ch. 1096.)

12681. An insurer shall not be required to issue a converted policy providing benefits in excess of those provided under the group policy from which conversion is made.

(Added by Stats. 1981, Ch. 1096, Sec. 2. Operative January 1, 1983, by Sec. 5 of Ch. 1096.)

12682. The converted policy shall not exclude, as a preexisting condition, any condition covered by the group policy. The converted policy may provide for a reduction of its benefits by the amount of any such benefits payable under the group policy after the individual's insurance terminates thereunder. The converted policy may also provide that during the first policy year the benefits payable under the converted policy, together with the benefits payable under the group policy, shall not exceed those that would have been payable had the individual's coverage under the group policy remained in effect.

12682.1. This section does not apply to a policy that primarily or solely supplements Medicare. The commissioner may adopt rules consistent with federal law to govern the discontinuance and replacement of plan policies that primarily or solely supplement Medicare.

(a) (1) Every group policy entered into, amended, or renewed on or after September 1, 2003, that provides hospital, medical, or surgical expense benefits for employees or members shall provide that an employee or member whose coverage under the group policy has been terminated by the employer shall be entitled to convert to nongroup membership, without evidence of insurability, subject to the terms and conditions of this section.

(2) If the health insurer provides coverage under an individual health insurance policy, other than conversion coverage under this part, it shall offer one of the two health insurance policies that the insurer is required to offer to a federally eligible defined individual pursuant to Section 10785. The health insurer shall provide this coverage at the same rate established under Section 10901.3 for a federally eligible defined individual.

(3) If the health insurer does not provide coverage under an individual health insurance policy, it shall offer a health benefit plan contract that is the same as a health benefit contract offered to a federally eligible defined individual pursuant to Section 1366.35. The health insurer shall offer the most popular preferred provider organization plan that has the greatest number of enrolled individuals for its type of plan as of January 1 of the prior year, as reported by plans by January 31, 2003, and annually thereafter, that provide coverage under an individual health care service plan contract to the department or the Department of Managed Health Care. A health insurer subject to this paragraph shall provide this coverage with the same cost-sharing terms and at the same premium as a health care service plan providing coverage to that individual under an individual health care service plan contract pursuant to Section 1399.805. The health insurer shall file the health benefit plan contract it will offer, including the premium it will charge and the cost-sharing terms of the contract, with the Department of Insurance.

(b) A conversion policy shall not be required to be made available to an employee or insured if termination of his or her coverage under the group policy occurred for any of the following reasons:

(1) The group policy terminated or an employer's participation terminated and the insurance is replaced by similar coverage under another group policy within 15 days of the date of termination of the group coverage or the employer's participation.

(2) The employee or insured failed to pay amounts due the health insurer.

(3) The employee or insured was terminated by the health insurer from the policy for good cause.

(4) The employee or insured knowingly furnished incorrect information or otherwise improperly obtained the benefits of the policy.

(5) The employer's hospital, medical, or surgical expense benefit program is self-insured.

(c) A conversion policy is not required to be issued to any person if any of the following facts are present:

(1) The person is covered by or is eligible for benefits under Title XVIII of the United States Social Security Act.

(2) The person is covered by or is eligible for hospital, medical, or surgical benefits under any arrangement of coverage for individuals in a group, whether insured or self-insured.

(3) The person is covered for similar benefits by an individual policy or contract.

(4) The person has not been continuously covered during the three-month period immediately preceding that person's termination of coverage.

(d) Benefits of a conversion policy shall meet the requirements for benefits under this chapter.

(e) Unless waived in writing by the insurer, written application and first premium payment for the conversion policy shall be made not later than 63 days after termination from the group. A conversion policy shall be issued by the insurer which shall be effective on the day following the termination of coverage under the group contract if the written application and the first premium payment for the conversion contract are made to the insurer not later than 63 days after the termination of coverage, unless these requirements are waived in writing by the insurer.

(f) The conversion policy shall cover the employee or insured and his or her dependents who were covered under the group policy on the date of their termination from the group.

(g) A notification of the availability of the conversion coverage shall be included in each evidence of coverage or other legally required document explaining coverage. However, it shall be the sole responsibility of the employer to notify its employees of the availability, terms, and conditions of the conversion coverage which responsibility shall be satisfied by notification within 15 days of termination of group coverage. Group coverage shall not be deemed terminated until the expiration of any continuation of the group coverage. For purposes of this subdivision, the employer shall not be deemed the agent of the insurer for purposes of notification of the availability, terms, and conditions of conversion coverage.

(h) As used in this section, "hospital, medical, or surgical benefits under state or federal law" do not include benefits under 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, or Title XIX of the United States Social Security Act.

(i) (1) On and after January 1, 2014, and except as provided in paragraph (2), this section shall not apply to any health insurance policies.

(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. Section 300gg-91), paragraph (1) shall become inoperative on the date of that repeal or amendment and this section shall apply to health insurance policies issued, renewed, or amended on or after that date.

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

(Amended by Stats. 2013, Ch. 441, Sec. 24. (AB 1180) Effective October 1, 2013.)

12682.2. (a) (1) At least 60 days prior to the policy renewal date, an insurer that does not otherwise issue individual health insurance policies shall issue the notice described in paragraph (2) to any policyholder of an individual health insurance policy issued pursuant to Section 12682.1 that is not a grandfathered health plan.

(2) The notice shall be in at least 12-point type and shall include all of the following information:

(A) Notice that, as of the renewal date, the individual policy will not be renewed.

(B) The availability of individual health coverage through Covered California, including at least all of the following:

(i) That, beginning on January 1, 2014, individuals seeking coverage may not be denied coverage based on health status.

(ii) That the premium rates for coverage offered by a health care service plan or a health insurer cannot be based on an individual's health status.

(iii) That individuals obtaining coverage through Covered California may, depending upon income, be eligible for premium subsidies and cost-sharing subsidies.

(iv) That individuals seeking coverage must obtain this coverage during an open or special enrollment period, and describe the open and special enrollment periods that may apply.

(b) (1) At least 60 days prior to the policy renewal date, an insurer that issues individual health insurance policies shall issue the notice described in paragraph (2) to a policyholder of an individual health insurance policy issued pursuant to Section 10785 or 12682.1 that is not a grandfathered health plan.

(2) The notice shall be in at least 12-point type and shall include all of the following:

(A) Notice that, as of the renewal date, the individual policy shall not be renewed.

(B) Information regarding the individual health insurance policy that the insurer will issue as of January 1, 2014, which the insurer has reasonably concluded is the most comparable to the individual's current policy. The notice shall include information on premiums for the possible replacement policy and instructions that the individual can continue their coverage by paying the premium stated by the due date.

(C) Notice of the availability of other individual health coverage through Covered California, including at least all of the following:

(i) That, beginning on January 1, 2014, individuals seeking coverage may not be denied coverage based on health status.

(ii) That the premium rates for coverage offered by a health care service plan or a health insurer cannot be based on an individual's health status.

(iii) That individuals obtaining coverage through Covered California may, depending upon income, be eligible for premium subsidies and cost-sharing subsidies.

(iv) That individuals seeking coverage must obtain this coverage during an open or special enrollment period, and describe the open and special enrollment periods that may apply.

(c) No later than September 1, 2013, the commissioner, in consultation with the Department of Managed Health Care, shall adopt uniform model notices that health insurers shall use to comply with subdivisions (a) and (b) and Sections 10127.16, 10786, and 10965.13. Use of the model notices shall not require prior approval by the department. The model notices adopted for purposes of this section shall not be subject to the Administrative Procedure Act (Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code). The commissioner may modify the wording of these model notices specifically for purposes of clarity, readability, and accuracy.

(d) The notices required under this section are vital documents, pursuant to clause (iii) of subparagraph (B) of paragraph (1) of subdivision (b) of Section 10133.8, and shall be subject to the requirements of that section.

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

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

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

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

(Added by Stats. 2013, Ch. 441, Sec. 25. (AB 1180) Effective October 1, 2013.)

12683. Subject to the provisions and conditions of this part, if the group policy from which conversion is made covers the employee or member for basic hospital or surgical expense, the employee or member shall be entitled to obtain a converted policy providing at least the following minimum benefits:

(a) Plan A.

(1) Hospital room and board daily expense benefits up to two hundred dollars (\$200) for a duration of 70 days.

(2) Miscellaneous hospital expense benefits up to an amount of 10 times the hospital room and board daily expense benefits.

(3) Surgical expense benefits according to a surgical procedures schedule consistent with those customarily offered by the insurer under a group or individual health insurance policy and providing a maximum benefit of four thousand eight hundred dollars (\$4,800).

(b) Plan B—75 percent of the dollar amounts of Plan A.

(c) Plan C—50 percent of the dollar amounts of Plan A.

(d) The maximum dollar amount for Plan A's hospital room and board daily expense and surgical benefit may be redetermined by the Insurance Commissioner as to conversion coverage issued subsequent to that redetermination. The redetermination shall not be made more often than once in three years. The maximum dollar amount redetermined by the commissioner for hospital room and board shall not exceed 80 percent of the average semiprivate room rate then charged in the state.

(e) Covered expenses under this section shall include benefits for expense incurred by the employee, member, or spouse in connection with pregnancy, provided that:

(1) The pregnancy commenced while covered under the group policy from which conversion was made.

(2) The expense is of a type which would have been covered under such group policy.

(3) The conversion policy is in force when the expense is incurred.

(Amended by Stats. 1993, Ch. 1210, Sec. 10. Effective January 1, 1994.)

12684. Subject to the provisions and conditions of this part, if the group policy from which conversion is made provides the employee or member with major medical or comprehensive medical insurance, the employee or member shall be entitled to obtain a converted policy providing comprehensive medical coverage providing at least the following benefits:

(a) A payment per covered person for all covered medical expenses incurred during the person's lifetime equal to one hundred thousand dollars (\$100,000); provided, however, that for treatment of mental illness payment may be limited to ten thousand dollars (\$10,000) during the person's lifetime.

(b) Payment of benefits at the rate of 75 percent of covered medical expenses; provided, however, that if coverage is provided for expenses incurred for outpatient treatment of mental illness, payment of benefits may be at the rate of 50 percent of such covered expenses, and the insurer may limit the amount of covered expense for each outpatient visit and the amount of benefits payable for expenses incurred during each calendar year for that outpatient treatment.

(c) A cash deductible for each benefit period at the option of the insured of two hundred dollars (\$200), five hundred dollars (\$500), or one thousand dollars (\$1,000), but not less than the cash deductible which applied to the insured under the group policy which entitles him or her to a converted policy.

(d) Covered medical expenses shall include the charges for a semiprivate hospital room and board, but need not exceed the lesser of two hundred dollars (\$200) per day or the hospital's most common charge for a semiprivate room, covered expenses for intensive care shall be at least two and one-half times the covered hospital room and board charge. The maximum dollar amount for hospital room and board daily covered expense may be redetermined by the commissioner as to conversion coverage issued after the redetermination. That redetermination shall not be made more often than once in three years. The maximum dollar amount redetermined by the commissioner shall not exceed the average semiprivate room rate then charged in the state.

(e) Covered expenses under this section shall include benefits for expense incurred by the employee, member, or spouse in connection with pregnancy, provided that:

(1) The pregnancy commenced while covered under the group policy from which conversion was made.

(2) The expense is of a type which would have been covered under such group policy.

(3) The conversion policy is in force when the expense is incurred.

(f) Covered expense under this section need not include expense for dental or vision care, or other optional benefits not normally offered by the insurer under a major medical or comprehensive medical expense plan.

(Amended by Stats. 1993, Ch. 1210, Sec. 11. Effective January 1, 1994.)

12685. The insurer may, at its option, offer alternative plans for group health conversion in addition to those required by this part.

(Added by Stats. 1981, Ch. 1096, Sec. 2. Operative January 1, 1983, by Sec. 5 of Ch. 1096.)

12686. (a) In the event coverage would be continued under a group policy on an employee or member following his or her retirement prior to the time he or she is or could be covered by Medicare, the employee or member may elect, in lieu of the continuation of group insurance, to have the same conversion rights as would apply had that coverage terminated at retirement by reason of termination of employment or membership.

(b) The converted policy may provide for reduction or termination of coverage of any person upon his or her eligibility for coverage under Medicare or under any other state or federal law providing for benefits similar to those provided by the converted policy. As used in this section, "state or federal law" does not include 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, or Title XIX of the United States Social Security Act.

(c) Subject to the conditions set forth herein, the conversion coverage shall also be available to:

(1) A covered dependent spouse and such children whose coverage terminates under the group policy by reason of the death of the employee or member, or a covered dependent spouse in the event such person ceases to be a qualified family member by reason of the termination of the marriage.

(2) A child, solely with respect to himself or herself, whose coverage terminates because the child ceases to be a qualified family member under the group policy.

(d) If the benefit levels required in Section 12683 or Section 12684 exceed the benefit levels provided under the group policy, the converted policy may offer benefits which are substantially similar to those provided under the group policy in lieu of those required in Section 12683 or Section 12684.

(e) The insurer may elect to provide conversion coverage through a group insurance policy issued for that purpose in lieu of an individual policy.

(f) An insurer required by this part to provide conversion coverage may provide such coverage through one or more other insurers authorized to provide disability insurance coverage in this state.

(Amended by Stats. 1982, Ch. 1186, Sec. 10.5.)

12687. Notwithstanding any other provision in this part, whenever an employee or member chooses among two or more conversion policies, such choice shall be made within 31 days from the last date when the employee or member was eligible for benefits under a group policy from which conversion is available.

(Amended by Stats. 1982, Ch. 1186, Sec. 11.)

12688. Notwithstanding any provision in this part to the contrary, a hospital service corporation or any insurer which customarily offers individual conversion coverage on a service basis may, in lieu of the expense incurred conversion coverage provided in Sections 12683 and 12684, make available conversion coverage on a service basis which complies with the intent of this part as approved by the commissioner.

(Added by Stats. 1981, Ch. 1096, Sec. 2. Operative January 1, 1983, by Sec. 5 of Ch. 1096.)

12689. A notification of the conversion coverage shall be included in each certificate of coverage or other legally required document explaining coverage; provided, however, that it shall be the sole responsibility of the policyholder to notify its employees or members of the availability, terms and conditions of conversion coverage which responsibility shall be satisfied by notification within 15 days of termination of group coverage. Group coverage shall not be deemed terminated until the expiration of any continuation of the group coverage. For purposes of this part, the policyholder shall not be deemed to be the agent of the insurer for purposes of notification of the availability, terms and conditions of conversion coverage.

(Amended by Stats. 1984, Ch. 914, first Sec. 5.)

12690. Nothing in this part shall prohibit insurers from establishing one or more pools from which the converted policies provided for on this part may be issued.

(Added by Stats. 1981, Ch. 1096, Sec. 2. Operative January 1, 1983, by Sec. 5 of Ch. 1096.)

12691. A converted policy which is delivered in a jurisdiction other than this state may be in a form which could be delivered in such jurisdiction as a converted policy had the group policy been issued in such jurisdiction.

(Added by Stats. 1981, Ch. 1096, Sec. 2. Operative January 1, 1983, by Sec. 5 of Ch. 1096.)

12692. On and after January 1, 1985, every insurer and nonprofit hospital service plan issuing group disability insurance which covers hospital, medical, or surgical expenses shall offer to group policyholders a continuation benefit which, if selected, shall have a duration of at least 90 days and which shall be offered consecutively to any federal requirement for continuation benefits. The terms and conditions shall include continuation benefit coverage for widows, widowers, divorced or legally separated spouses, spouses of covered employees becoming entitled to benefits under Title XVIII of the Social Security Act, and their dependents, including dependent children who cease to be dependent children under the plan, who were covered by the group contract on the date of termination of coverage. However, any existing provisions of law regarding termination of a dependent child status shall not be affected by this section.

The continuation of coverage shall be available only under the following conditions:

(a) Those eligible remain within the State of California, although the departure of a dependent child to another state shall not invalidate the continuation provisions for any other family members.

(b) Those eligible do not marry or remarry, although the marriage of any dependent child shall not invalidate the continuation provisions for other family members.

(c) Those eligible are not eligible for any comparable state, federal, or private group medical plan, although the eligibility of any dependent child shall not invalidate the continuation provisions for other family members.

(d) Those eligible do not find employment with an employer that has a group plan of its own, even if the plan is less substantive, although the entry into such an employee plan by a dependent child shall not invalidate the continuation provisions for other family members.

(e) The group policy is not terminated or the employer's participation in the group policy is not terminated.

(f) Those eligible do not knowingly furnish incorrect information or otherwise improperly obtain the benefits of the plan.

(g) The continuing individual shall pay the premium amount in the manner specified in the group policy for both his or her share of the premium and the group policyholder's share, if any.

(h) Eligible persons under this section shall be notified in the same manner required for conversion notification pursuant to Section 12689. Every insurer shall communicate the availability of such coverage to all group policyholders and to all prospective group policyholders with whom they are negotiating.

(Amended by Stats. 1988, Ch. 960, Sec. 2.)

12692.5. Notwithstanding any other provision of this part, Sections 12672, 12673, 12674, 12675, 12676, 12677, 12678, 12679, 12680, 12681, 12682, 12683, 12684, 12685, 12686, 12687, 12688, 12689, 12690, 12691, and 12692 shall not apply to a group policy that is issued, amended, or renewed on or after September 1, 2003.

(Added by Stats. 2002, Ch. 799, Sec. 4. Effective January 1, 2003. Operative September 1, 2003, by Sec. 5 of Ch. 799.)