CA

1300.43.13 Mutual Benefit Plans

A health care service plan which is a bona fide mutual benefit society within the meaning of this section and which was registered under the Knox-Mills Health Plan Act as in effect on June 30, 1976 is exempted from the provisions of the Knox-Keene Health Care Service Plan Act, except as otherwise indicated below, subject to each of the following conditions:

(a)

That such a plan is a corporation organized and operating as a California nonprofit corporation; does not engage, directly or indirectly, in any for-profit business; is not affiliated (Rule 1300.45(c)) with any other plan or with any corporation or other entity which engages, directly or indirectly, in any for-profit business; and does not contract or otherwise arrange for the performance of any portion of its administrative functions by persons other than its officers, directors, or employees.

(b)

That such plan consists of a mother lodge and not more than one subordinate lodge; provided, however, that such mother lodge and any such subordinate lodge are located in a county whose population exceeds 1,500,000 persons.

(c)

That the assets and funds available for the payment of health care services are held in trust by and under the sole control of the mother lodge exclusively for the

benefit of the beneficiary members of the mother lodge and any subordinate lodge.

(d)

That such plan is exempted from federal income tax as an organization described in Section 501(c)(8) of the Internal Revenue Code and from state income tax on similar grounds.

(e)

That such plan is in compliance with the Uniform Supervision of Trustees for Charitable Purposes Act (Article 7 (commencing with Section 12580) of Chapter 6 of Part 2 of Division 3 of Title 2 of the Government Code.)

(f)

That such plan not practice any discrimination in violation of state or federal law or constitutional provision.

(g)

That the beneficial membership in such plan is limited to beneficial members of the mutual benefit society (including only the mother lodge and any subordinate lodge) and consists of a total of not more than 800 persons.

(h)

That such plan not receive any prepaid or periodic charges, except that admission fees of not more than $500 per each beneficial or social member may be received and dues of not more than $100 per each beneficial or social member per year may be received, provided, however, that no part of any admission fees or membership dues may be deposited in the health care trust or used to pay for or reimburse any part of the cost of health care services.

(i)

That such plan, at all times while it relies upon this exemption, has a tangible net

equity within the meaning of Section 1300.76(b) of not less than $500,000, including liquid tangible assets in an amount not less than $500,000, based upon its most recent annual certified financial statement and its most recent quarterly and monthly statements prepared on a basis consistent with the annual certified statement, with additional liquid tangible assets in an amount not less than $1,000 for each beneficial member in excess of 700; provided that the maximum number of beneficial members shall not exceed 800.

(j)

That such plan, upon request of the Director, pursuant to Section 1384(a) of the Act, submits to the Director a copy of its most recent annual certified financial statement, and, upon request of the Director pursuant to Section 1384(f) of the Act, submits to the Director its most recent quarterly and monthly statements prepared on a basis consistent with the annual certified statement.

(k)

That such plan issues to all beneficial members health care service plan contracts which provide at least all of the benefits indicated below, except that such contracts may diminish or qualify any of the benefits indicated below through the use of such copayments, limitations, and other terms as may be determined from time to time by vote of the plan's beneficial members:(1) Physician services (including consultation and referral) through contracting physicians; (2) Hospital inpatient services through at least one contracting nonprofit, nongovernmental hospital; (3) Hospital outpatient services through at least one contracting nonprofit, nongovernmental hospital when prescribed by the treating, contracting physician.

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(3)

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(l)

That all of the plan's contracts with providers comply with, and recite that the contracting providers are bound by, the provisions of Section 1379 of the Act.

(m)

That such plan provides to each beneficial member a disclosure statement covering the provisions of its health care service plan contract which complies substantially with the provisions of Section 1363 of the Act.

(n)

That the officers and directors of such corporation are enrolled in such plan subject to terms and conditions no more favorable than any other beneficial member, and that no officer or director receives any compensation from such corporation.

(o)

That such plan solicits beneficial members in this state only through persons who are officers, directors, or employees of such plan, and not by means of any unsolicited telephone call or written or printed communication or by radio, television, or similar communications media.

(p)

That such plan establishes and maintains a grievance procedure substantially

complying with Section 1368 of the Act.

(q)

That such plan delivers to each beneficial member within 60 days of the effective date of this section, and annually thereafter, the following written notice: "(Name of Plan) IS A HEALTH CARE SERVICE PLAN OPERATING PURSUANT TO AN EXEMPTION FROM THE KNOX-KEENE HEALTH CARE SERVICE PLAN ACT OF 1975. COMPLAINTS REGARDING THIS PLAN, THE ADMINISTRATION THEREOF, AND THE SERVICES PROVIDED THEREBY MAY BE DIRECTED TO THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE OF THE STATE OF CALIFORNIA."

(r)

That such plan provides, within 60 days of its initial reliance on this section, and within 30 days of any subsequent request of the Director therefor, written notice to the Director of its intent to rely on the exemption provided by this section, executed by a duly authorized officer of such plan, together with a signed opinion of legal counsel to the effect that such plan complies with subsections (a), (b), (c), (d), (e), (f), (g), (h), (i), (k), (l), and (m) of this section.