

## 1300.43.15 Foreign Plans

### (a)

There is exempted from the provisions of the Act (other than Sections 1360, 1360.1, 1381 and 1395) any plan whose activity in this state is limited to the offer and sale of plan contracts for enrollees who are residents of or domiciled in a foreign country, provided: (1) the provision of health care services by the plan, and the receipt of consideration from persons located in this State, does not violate any law of the foreign country in which the enrollee resides or any law of the United States, (2) the annual premium per enrollee does not exceed \$200 (US), (3) the solicitors or solicitor firms authorized to solicit on behalf of the plan are physically present in this state, and (4) the plan has filed a notice with the Director as provided in subsection (b) within the preceding 24 months.

### (1)

the provision of health care services by the plan, and the receipt of consideration from persons located in this State, does not violate any law of the foreign country in which the enrollee resides or any law of the United States,

### (2)

the annual premium per enrollee does not exceed \$200 (US),

### (3)

the solicitors or solicitor firms authorized to solicit on behalf of the plan are physically present in this state, and

**(4)**

the plan has filed a notice with the Director as provided in subsection (b) within the preceding 24 months.

**(b)**

The notice specified in subsection (a) shall be in the following form and contain the information specified below: DEPARTMENT OF MANAGED HEALTH CARE  
STATE OF CALIFORNIA NOTICE OF FOREIGN PLAN EXEMPTION RULE 1300.43.15,  
KNOX-KEENE HEALTH CARE SERVICE PLAN ACT ( ) Original Notice( ) Amendment  
to Notice Dated\_\_\_\_\_ The person/entity named in Item 1  
below files this notice/amended notice claiming the exemption pursuant to Rule  
1300.43.15 under the Knox-Keene Health Care Service Plan Act: 1. Legal name of  
person or entity filing this notice: 2. Address of principal office, and if different,  
mailing address: 3. List name, address and telephone number of authorized  
solicitors or solicitor firms who will be soliciting on behalf of the plan in this state.  
(Continue on separate sheet if space is insufficient.) 4. Name, title, address and  
telephone number of representative who may be contacted concerning this  
notice: 5. The person/entity filing this notice declares hereby that it is in  
compliance with the provisions of Rule 1300.43.15, and undertakes to amend this  
notice within 30 calendar days of any material change in the information specified  
in it current notice as filed with the Director of the Department of Managed Health  
Care. Date of Notice\_\_\_\_\_ (Name of Person/Entity Filing  
Notice) \_\_\_\_\_ (Signature of  
Authorized Officer) \_\_\_\_\_ (Printed Name and Title of  
Signatory) Verification: I certify (or declare) under penalty of perjury under the  
laws of the State of California that I have read this Notice and its attachments  
thereto and know the contents thereof and that the statements therein are true

and correct. Executed at \_\_\_\_\_ (City and State) \_\_\_\_\_ (Date).

\_\_\_\_\_ (Signature)

**1.**

Legal name of person or entity filing this notice:

**2.**

Address of principal office, and if different, mailing address:

**3.**

List name, address and telephone number of authorized solicitors or solicitor firms who will be soliciting on behalf of the plan in this state. (Continue on separate sheet if space is insufficient.)

**4.**

Name, title, address and telephone number of representative who may be contacted concerning this notice:

**5.**

The person/entity filing this notice declares hereby that it is in compliance with the provisions of Rule 1300.43.15, and undertakes to amend this notice within 30 calendar days of any material change in the information specified in its current notice as filed with the Director of the Department of Managed Health Care. Date of

Notice \_\_\_\_\_ (Name of Person/Entity Filing Notice)

\_\_\_\_\_ (Signature of Authorized

Officer) \_\_\_\_\_ (Printed Name and Title of Signatory)

Verification: I certify (or declare) under penalty of perjury under the laws of the State of California that I have read this Notice and its attachments thereto and know the contents thereof and that the statements therein are true and correct. Executed at

\_\_\_\_\_ (City and State) \_\_\_\_\_ (Date). \_\_\_\_\_

(Signature)