CA

1300.65 Cancellations, Rescissions, and Nonrenewals of an Enrollment or Subscription

(a)

Definitions The terms used in Health and Safety Code sections 1365 and 1389.21, as well as the terms used in this Article, are defined as follows: (1) "APTC enrollee" means an individual, an enrollee or a subscriber in the individual market who is currently a recipient of advance payments of the premium tax credit ("APTC") pursuant to the federal Patient Protection and Affordable Care Act ("PPACA") at section 1401 (26 U.S.C. § 36B). (2) "Billed for the charge" means the enrollee, subscriber, or group contract holder was sent a bill that provides, at a minimum, an accurate itemization of the premium amount(s) due, the due date(s), and the period(s) of time covered by the premium(s). The bill shall also include the following statement in at least 12-point font: Your health plan is billing you for the cost of your health coverage. You must pay all amounts listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage can be cancelled. You will receive a grace period before your plan can cancel your coverage for not paying the amount due. You can file a complaint with your plan and with the California Department of Managed Health Care if you think there is a mistake. Learn more about your health care rights and responsibilities in your plan Evidence of Coverage. (3) "Cancelled," "not renewed" or "nonrenewal" means termination of coverage initiated by the plan during or at the conclusion of

the contract term, but does not include the following: (A) Voluntary termination at the request of the enrollee or subscriber. (B) Termination for failure to satisfy any statutory or regulatory eligibility requirements under federal or state law. (C) Exhaustion of any time-limited coverage provided by federal or state law, including, but not limited to, continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (section 4980B of Title 26 of the United States Code, sections 1161 et seq. of Title 29 of the United States Code, and section 300 bb of Title 42 of the United States Code) or Cal-COBRA (Health and Safety Code sections 1366.20 through 1366.29). (D) Prospective termination for failure to satisfy eligibility requirements under a group plan contract, as follows: (i) Time-based employment requirements, including, but not limited to, a reduction in work hours; (ii) Marital or registered domestic partner status; (iii) Attainment of limiting age by dependent child; (iv) Group participation requirements; or (v) Service-area requirements. (4) "Contractholder" or "contract holder" means the enrollee, subscriber, group, association or employer with which the plan has contracted to provide health services. (5) "Enrollee" means a person who is enrolled in a plan and who is a recipient of services from the plan, as that term is defined in Health and Safety Code section 1345(c). (6) "Enrollment," "subscription," or "contract" means "plan contract," as that term is defined in Health and Safety Code section 1345(r). (7) "Exchange" or "Covered California" means the California Health Benefit Exchange established in Title 22 (commencing with section 100500) of the Government Code. (8) "Federal grace period" means the period of three consecutive months a QHP Issuer must provide to an APTC enrollee, before terminating the APTC enrollee's health care coverage for nonpayment of premiums. (9) "Grace period" means the period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated.

(10) "Grievance" means a written or oral expression of dissatisfaction to the plan or the Director regarding the plan and/or provider, including a written or oral expression of dissatisfaction by an enrollee, subscriber, or group contract holder who believes their plan contract, enrollment or subscription has been or will be improperly cancelled, rescinded or not renewed. The right to request a review by filing a complaint authorized under Health and Safety Code section 1365(b) shall be handled as an expedited grievance pursuant to the requirements of Health and Safety Code sections 1368 and 1368.01, and California Code of Regulations, title 28, sections 1300.68 and 1300.68.01. (11) "Group contract holder" means a group, association, or employer that contracts with a plan to provide health care services to members or employees. (12) "Individual" means enrollee or subscriber as defined in Health and Safety Code section 1345(c) and (p), respectively. (13) "Non-Suspension QHP Issuer" means a health care service plan that does not pend claims for services given to the APTC enrollee in the second and third months of the federal grace period. A Non-Suspension QHP Issuer shall provide coverage to the APTC enrollee as required by the plan contract during the 3-month federal grace period. (14) "Nonpayment of Premiums" means failure of the enrollee, subscriber, or group contract holder to pay any premium, or portion of premium, by the due date after having been billed for the charge. (15) "Notice of Cancellation, Rescission or Nonrenewal" means notice sent by the plan to the enrollee, subscriber, or group contract holder that the plan contract will be cancelled, rescinded or not renewed for any reason other than nonpayment of premiums as permitted under California Code of Regulations, title 28, sections 1300.65.1 or 1300.89.21, or Health and Safety Code sections 1365 or 1389.21. (16) "Notice of End of Coverage" means the notice sent to the enrollee, subscriber, or group contract holder notifying the recipient that the

enrollee's coverage has been cancelled. (17) "Notice of Start of Federal Grace Period" means notice sent by the plan to the enrollee or subscriber that the plan contract will be terminated unless the premium amount due is received by the plan no later than the last day of the Federal Grace Period. (18) "Notice of Start of Grace Period" means the notice sent by the plan to the enrollee, subscriber, or group contract holder that the plan contract will be terminated unless the premium amount due is received by the plan no later than the last day of the Grace Period. (19) "Outstanding premium" means the total premium amounts that have been billed to the enrollee, subscriber or group contract holder and are past due. (20) "Plan" means a "health care service plan" or "specialized health care service plan," as those terms are defined in Health and Safety Code section 1345(f). (21) "Premium payment threshold policy" means a plan's policy to consider an enrollee, subscriber, or group contract holder to have paid all amounts due if the enrollee, subscriber, or group contract holder pays an amount sufficient to maintain a percentage of total premium owed equal to or greater than a level prescribed by the plan, provided that the level is reasonable and that the level and policy are applied in a uniform manner to all enrollees, subscribers, contract holders, and group contract holders. (22) "QHP Issuer" means, for the purposes of this Article, a plan licensed under the provisions of the Act and certified by the Exchange to market individual and/or small group products on the Exchange. Any of the requirements contained in California Code of Regulations, title 28, sections 1300.65, 1300.65.1, 1300.65.2, and 1300.65.3 that are delegated by a QHP Issuer to a delegated group shall also apply to that delegated group. (23) "Qualified Health Plan" or "QHP" means a plan contract certified to be offered through the Exchange. (24) "Rescission" or "rescind" means retroactive cancellation of coverage as defined in California Code of Regulations, title 28,

section 1300.89.21. (25) "Small employer" has the same meaning as defined in Health and Safety Code sections 1357(l), 1357.500(k) and 1357.600(k). (26) "Suspension QHP Issuer" means a health care service plan that pends claims for services rendered to the enrollee in the second and third months of the federal grace period, pursuant to Title 45 of the Code of Federal Regulations, section 156.270.

(1)

"APTC enrollee" means an individual, an enrollee or a subscriber in the individual market who is currently a recipient of advance payments of the premium tax credit ("APTC") pursuant to the federal Patient Protection and Affordable Care Act ("PPACA") at section 1401 (26 U.S.C. § 36B).

(2)

"Billed for the charge" means the enrollee, subscriber, or group contract holder was sent a bill that provides, at a minimum, an accurate itemization of the premium amount(s) due, the due date(s), and the period(s) of time covered by the premium(s). The bill shall also include the following statement in at least 12-point font: Your health plan is billing you for the cost of your health coverage. You must pay all amounts listed in this bill by the due date. If you do not pay this amount by the due date, your health coverage can be cancelled. You will receive a grace period before your plan can cancel your coverage for not paying the amount due. You can file a complaint with your plan and with the California Department of Managed Health Care if you think there is a mistake. Learn more about your health care rights and responsibilities in your plan Evidence of Coverage.

(3)

"Cancelled," "not renewed" or "nonrenewal" means termination of coverage initiated by the plan during or at the conclusion of the contract term, but does not include the

following: (A) Voluntary termination at the request of the enrollee or subscriber. (B) Termination for failure to satisfy any statutory or regulatory eligibility requirements under federal or state law. (C) Exhaustion of any time-limited coverage provided by federal or state law, including, but not limited to, continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (section 4980B of Title 26 of the United States Code, sections 1161 et seq. of Title 29 of the United States Code, and section 300 bb of Title 42 of the United States Code) or Cal-COBRA (Health and Safety Code sections 1366.20 through 1366.29). (D) Prospective termination for failure to satisfy eligibility requirements under a group plan contract, as follows: (i) Time-based employment requirements, including, but not limited to, a reduction in work hours; (ii) Marital or registered domestic partner status; (iii) Attainment of limiting age by dependent child; (iv) Group participation requirements; or (v) Service-area requirements.

(A)

Voluntary termination at the request of the enrollee or subscriber.

(B)

Termination for failure to satisfy any statutory or regulatory eligibility requirements under federal or state law.

(C)

Exhaustion of any time-limited coverage provided by federal or state law, including, but not limited to, continuation coverage under the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (section 4980B of Title 26 of the United States Code, sections 1161 et seq. of Title 29 of the United States Code, and section 300 bb of Title 42 of the United States Code) or Cal-COBRA (Health and Safety Code sections 1366.20 through 1366.29).

(D)

Prospective termination for failure to satisfy eligibility requirements under a group plan contract, as follows: (i) Time-based employment requirements, including, but not limited to, a reduction in work hours; (ii) Marital or registered domestic partner status; (iii) Attainment of limiting age by dependent child; (iv) Group participation requirements; or (v) Service-area requirements.

(i)

Time-based employment requirements, including, but not limited to, a reduction in work hours;

(ii)

Marital or registered domestic partner status;

(iii)

Attainment of limiting age by dependent child;

(iv)

Group participation requirements; or

(v)

Service-area requirements.

(4)

"Contractholder" or "contract holder" means the enrollee, subscriber, group, association or employer with which the plan has contracted to provide health services.

(5)

"Enrollee" means a person who is enrolled in a plan and who is a recipient of services from the plan, as that term is defined in Health and Safety Code section 1345(c).

(6)

"Enrollment," "subscription," or "contract" means "plan contract," as that term is defined in Health and Safety Code section 1345(r).

(7)

"Exchange" or "Covered California" means the California Health Benefit Exchange

established in Title 22 (commencing with section 100500) of the Government Code.

(8)

"Federal grace period" means the period of three consecutive months a QHP Issuer must provide to an APTC enrollee, before terminating the APTC enrollee's health care coverage for nonpayment of premiums.

(9)

"Grace period" means the period of at least 30 consecutive days beginning the day the Notice of Start of Grace Period is dated.

(10)

"Grievance" means a written or oral expression of dissatisfaction to the plan or the Director regarding the plan and/or provider, including a written or oral expression of dissatisfaction by an enrollee, subscriber, or group contract holder who believes their plan contract, enrollment or subscription has been or will be improperly cancelled, rescinded or not renewed. The right to request a review by filing a complaint authorized under Health and Safety Code section 1365(b) shall be handled as an expedited grievance pursuant to the requirements of Health and Safety Code sections 1368 and 1368.01, and California Code of Regulations, title 28, sections 1300.68 and 1300.68.01.

(11)

"Group contract holder" means a group, association, or employer that contracts with a plan to provide health care services to members or employees.

(12)

"Individual" means enrollee or subscriber as defined in Health and Safety Code section 1345(c) and (p), respectively.

(13)

"Non-Suspension QHP Issuer" means a health care service plan that does not pend

claims for services given to the APTC enrollee in the second and third months of the federal grace period. A Non-Suspension QHP Issuer shall provide coverage to the APTC enrollee as required by the plan contract during the 3-month federal grace period.

(14)

"Nonpayment of Premiums" means failure of the enrollee, subscriber, or group contract holder to pay any premium, or portion of premium, by the due date after having been billed for the charge.

(15)

"Notice of Cancellation, Rescission or Nonrenewal" means notice sent by the plan to the enrollee, subscriber, or group contract holder that the plan contract will be cancelled, rescinded or not renewed for any reason other than nonpayment of premiums as permitted under California Code of Regulations, title 28, sections 1300.65.1 or 1300.89.21, or Health and Safety Code sections 1365 or 1389.21.

(16)

"Notice of End of Coverage" means the notice sent to the enrollee, subscriber, or group contract holder notifying the recipient that the enrollee's coverage has been cancelled.

(17)

"Notice of Start of Federal Grace Period" means notice sent by the plan to the enrollee or subscriber that the plan contract will be terminated unless the premium amount due is received by the plan no later than the last day of the Federal Grace Period.

(18)

"Notice of Start of Grace Period" means the notice sent by the plan to the enrollee, subscriber, or group contract holder that the plan contract will be terminated unless the premium amount due is received by the plan no later than the last day of the Grace Period.

(19)

"Outstanding premium" means the total premium amounts that have been billed to the enrollee, subscriber or group contract holder and are past due.

(20)

"Plan" means a "health care service plan" or "specialized health care service plan," as those terms are defined in Health and Safety Code section 1345(f).

(21)

"Premium payment threshold policy" means a plan's policy to consider an enrollee, subscriber, or group contract holder to have paid all amounts due if the enrollee, subscriber, or group contract holder pays an amount sufficient to maintain a percentage of total premium owed equal to or greater than a level prescribed by the plan, provided that the level is reasonable and that the level and policy are applied in a uniform manner to all enrollees, subscribers, contract holders, and group contract holders.

(22)

"QHP Issuer" means, for the purposes of this Article, a plan licensed under the provisions of the Act and certified by the Exchange to market individual and/or small group products on the Exchange. Any of the requirements contained in California Code of Regulations, title 28, sections 1300.65, 1300.65.1, 1300.65.2, and 1300.65.3 that are delegated by a QHP Issuer to a delegated group shall also apply to that delegated group.

(23)

"Qualified Health Plan" or "QHP" means a plan contract certified to be offered through the Exchange.

(24)

"Rescission" or "rescind" means retroactive cancellation of coverage as defined in California Code of Regulations, title 28, section 1300.89.21.

(25)

"Small employer" has the same meaning as defined in Health and Safety Code sections 1357(l), 1357.500(k) and 1357.600(k).

(26)

"Suspension QHP Issuer" means a health care service plan that pends claims for services rendered to the enrollee in the second and third months of the federal grace period, pursuant to Title 45 of the Code of Federal Regulations, section 156.270.

(b)

Grievance (1) An enrollee, subscriber, or group contract holder who believes a plan contract, enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed shall have at least 180 days from the date of the notice that the enrollee, subscriber, or group contract holder alleges to be improper to submit a grievance to the plan. An enrollee, subscriber, or group contract holder may also submit a grievance to the Director. An enrollee, subscriber, or group contract holder's right to submit a grievance is pursuant to Health and Safety Code sections 1365, 1368, and 1368.01. (2) A grievance of an enrollee, subscriber, or group contract holder to the plan shall be processed pursuant to California Code of Regulations, title 28, section 1300.68.01. If the enrollee, subscriber, or group contract holder submits a grievance to the plan regarding a cancellation, rescission, or nonrenewal, the plan shall provide the Department and the enrollee, subscriber, or group contract holder with a disposition or pending status on the grievance within three (3) calendar days of receipt of the grievance by the plan pursuant to Health and Safety Code section 1368 and California Code of Regulations, title 28, section 1300.68.01(a)(2). Health and Safety Code section 1368(a)(4)(B)(i) and California Code of Regulations, title 28, section 1300.68(d)(8) shall not exempt a plan from complying with any requirement for

written acknowledgement and response to an enrollee's grievance, as that term is defined in this Article. (3) An enrollee, subscriber, or group contract holder's grievance to the Director shall be processed to determine if a proper complaint exists pursuant to Health and Safety Code section 1365(b)(2), including a determination if the grievance is timely, complete, and within the Director's jurisdiction. If a proper complaint does exist, the Director shall notify the enrollee, subscriber, or group contract holder, and the plan that the grievance has been accepted within 48 hours of the determination that the grievance is a proper complaint. (4) Within 1 business day of receipt of the Director's notice of acceptance of proper complaint, the plan shall provide the Director with a copy of all information the plan used to make its determination and all other relevant information necessary for the Director's review pursuant to California Code of Regulations, title 28, section 1300.68(g)(1) through (g)(6). (5) If an enrollee, subscriber, or group contract holder submits a grievance before the effective date of a cancellation, rescission, or nonrenewal, the plan shall continue to provide coverage as specified in California Code of Regulations, title 28, section 1300.65(c). (6) Within 30 calendar days of the receipt of a grievance, or longer if the Director determines in his or her discretion that additional time is necessary to review the cancellation, rescission, or nonrenewal, the Director shall, pursuant to Health and Safety Code section 1368(b)(5), send written notice of the final determination and reasons for the determination to the enrollee, subscriber, or group contract holder, and to the plan. (7) If the Director determines the cancellation, rescission, or nonrenewal fails to comply with all legal requirements, including, but not limited to, all notice and timing requirements in this Article, the Director shall order reinstatement, in accordance with California Code of Regulations, title 28, section 1300.65(d), or direct the plan not to cancel

coverage. (8) If the Director finds the cancellation, rescission, or nonrenewal was proper, but the effective date was in violation of the requirements of this Article, the Director may exercise his or her discretion and adjust the effective date of the cancellation, rescission, or nonrenewal accordingly and notify the enrollee, subscriber, or group contract holder, as well as the plan of the adjusted cancellation date.

(1)

An enrollee, subscriber, or group contract holder who believes a plan contract, enrollment or subscription has been or will be improperly canceled, rescinded, or not renewed shall have at least 180 days from the date of the notice that the enrollee, subscriber, or group contract holder alleges to be improper to submit a grievance to the plan. An enrollee, subscriber, or group contract holder may also submit a grievance to the Director. An enrollee, subscriber, or group contract holder's right to submit a grievance is pursuant to Health and Safety Code sections 1365, 1368, and 1368.01.

(2)

A grievance of an enrollee, subscriber, or group contract holder to the plan shall be processed pursuant to California Code of Regulations, title 28, section 1300.68.01. If the enrollee, subscriber, or group contract holder submits a grievance to the plan regarding a cancellation, rescission, or nonrenewal, the plan shall provide the Department and the enrollee, subscriber, or group contract holder with a disposition or pending status on the grievance within three (3) calendar days of receipt of the grievance by the plan pursuant to Health and Safety Code section 1368 and California Code of Regulations, title 28, section 1300.68.01(a)(2). Health and Safety Code section 1368(a)(4)(B)(i) and California Code of Regulations, title 28, section 1300.68(d)(8) shall not exempt a plan from complying with any requirement for written acknowledgement and response to an enrollee's grievance, as that term is defined in

this Article.

(3)

An enrollee, subscriber, or group contract holder's grievance to the Director shall be processed to determine if a proper complaint exists pursuant to Health and Safety Code section 1365(b)(2), including a determination if the grievance is timely, complete, and within the Director's jurisdiction. If a proper complaint does exist, the Director shall notify the enrollee, subscriber, or group contract holder, and the plan that the grievance has been accepted within 48 hours of the determination that the grievance is a proper complaint.

(4)

Within 1 business day of receipt of the Director's notice of acceptance of proper complaint, the plan shall provide the Director with a copy of all information the plan used to make its determination and all other relevant information necessary for the Director's review pursuant to California Code of Regulations, title 28, section 1300.68(g)(1) through (g)(6).

(5)

If an enrollee, subscriber, or group contract holder submits a grievance before the effective date of a cancellation, rescission, or nonrenewal, the plan shall continue to provide coverage as specified in California Code of Regulations, title 28, section 1300.65(c).

(6)

Within 30 calendar days of the receipt of a grievance, or longer if the Director determines in his or her discretion that additional time is necessary to review the cancellation, rescission, or nonrenewal, the Director shall, pursuant to Health and Safety Code section 1368(b)(5), send written notice of the final determination and reasons for the determination to the enrollee, subscriber, or group contract holder, and

to the plan.

(7)

If the Director determines the cancellation, rescission, or nonrenewal fails to comply with all legal requirements, including, but not limited to, all notice and timing requirements in this Article, the Director shall order reinstatement, in accordance with California Code of Regulations, title 28, section 1300.65(d), or direct the plan not to cancel coverage.

(8)

If the Director finds the cancellation, rescission, or nonrenewal was proper, but the effective date was in violation of the requirements of this Article, the Director may exercise his or her discretion and adjust the effective date of the cancellation, rescission, or nonrenewal accordingly and notify the enrollee, subscriber, or group contract holder, as well as the plan of the adjusted cancellation date.

(c)

Continuation of Coverage (1) If the enrollee, subscriber, or group contract holder files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, the plan shall continue to provide coverage to the enrollee, subscriber, or contract holder pursuant to the terms of the plan contract while the grievance is pending with the plan and/or Director. (2) During the period of continued coverage, the enrollee, subscriber, or group contract holder remains responsible for paying premiums and any copayments, coinsurance, or deductible obligations as required under the plan contract. (3) If the Director determines the cancellation or nonrenewal for nonpayment of premiums is consistent with existing law, and if the enrollee or subscriber is not entitled to the federal grace period, the cancellation date shall comply with California Code of Regulations, title 28, section 1300.65.2(a)(5).

Under the federal grace period, if the Director determines the cancellation or nonrenewal is consistent with existing law, the cancellation date shall comply with California Code of Regulations, title 28, section 1300.65.3(a)(5)(A). The enrollee, subscriber, or group contract holder shall be responsible only for the required premium and cost sharing obligations incurred during the continued coverage period. (4) If the Director determines the rescission is consistent with existing law, the plan shall return all premiums paid by the enrollee, subscriber, or group contract holder. The enrollee, subscriber, or group contract holder is responsible for the cost of all medical services received after the effective date of the rescission as defined in California Code of Regulations, title 28, section 1300.89.21(a).

(1)

If the enrollee, subscriber, or group contract holder files a grievance before the effective date of a cancellation, rescission, or nonrenewal, for reasons other than nonpayment of premiums, the plan shall continue to provide coverage to the enrollee, subscriber, or contract holder pursuant to the terms of the plan contract while the grievance is pending with the plan and/or Director.

(2)

During the period of continued coverage, the enrollee, subscriber, or group contract holder remains responsible for paying premiums and any copayments, coinsurance, or deductible obligations as required under the plan contract.

(3)

If the Director determines the cancellation or nonrenewal for nonpayment of premiums is consistent with existing law, and if the enrollee or subscriber is not entitled to the federal grace period, the cancellation date shall comply with California Code of Regulations, title 28, section 1300.65.2(a)(5). Under the federal grace period, if the

Director determines the cancellation or nonrenewal is consistent with existing law, the cancellation date shall comply with California Code of Regulations, title 28, section 1300.65.3(a)(5)(A). The enrollee, subscriber, or group contract holder shall be responsible only for the required premium and cost sharing obligations incurred during the continued coverage period.

(4)

If the Director determines the rescission is consistent with existing law, the plan shall return all premiums paid by the enrollee, subscriber, or group contract holder. The enrollee, subscriber, or group contract holder is responsible for the cost of all medical services received after the effective date of the rescission as defined in California Code of Regulations, title 28, section 1300.89.21(a).

(d)

Reinstatement of Coverage (1) If the Director determines the cancellation, rescission, or nonrenewal, including a cancellation for nonpayment of premium, does not comply with existing law, and the enrollee, subscriber, or group contract holder submitted the grievance after the plan contract was cancelled, rescinded, or not renewed, the Director shall order the plan to reinstate the enrollee, subscriber, or contract holder, retroactive to the effective date of cancellation, rescission, or nonrenewal. (2) Within 15 days after receipt of the order for reinstatement, the plan shall either request an administrative hearing from the Director or reinstate the enrollee, subscriber, or contract holder. (3) If the Director orders reinstatement, the plan shall be liable for the expenses incurred by the enrollee, subscriber, or group contract holder for covered health care services, less any applicable deductibles, copayments, or coinsurance pursuant to the enrollee, subscriber, or group contract holder's Evidence of Coverage, from the effective date of cancellation, rescission, or nonrenewal through the date of

reinstatement. The plan shall reimburse the enrollee, subscriber, or group contract holder for any medical expenses incurred by the enrollee, subscriber, or contract holder pursuant to this subdivision within 30 days of receipt of the complete claim, as defined in California Code of Regulations, title 28, section 1300.71(a)(2). (4) The enrollee, subscriber, or group contract holder shall be responsible for any and all premium payments accrued from the effective date of cancellation, rescission, or nonrenewal. An enrollee, subscriber, or group contract holder must pay all outstanding premiums before reinstatement.

(1)

If the Director determines the cancellation, rescission, or nonrenewal, including a cancellation for nonpayment of premium, does not comply with existing law, and the enrollee, subscriber, or group contract holder submitted the grievance after the plan contract was cancelled, rescinded, or not renewed, the Director shall order the plan to reinstate the enrollee, subscriber, or contract holder, retroactive to the effective date of cancellation, rescission, or nonrenewal.

(2)

Within 15 days after receipt of the order for reinstatement, the plan shall either request an administrative hearing from the Director or reinstate the enrollee, subscriber, or contract holder.

(3)

If the Director orders reinstatement, the plan shall be liable for the expenses incurred by the enrollee, subscriber, or group contract holder for covered health care services, less any applicable deductibles, copayments, or coinsurance pursuant to the enrollee, subscriber, or group contract holder's Evidence of Coverage, from the effective date of cancellation, rescission, or nonrenewal through the date of reinstatement. The plan shall reimburse the enrollee, subscriber, or group contract holder for any medical

expenses incurred by the enrollee, subscriber, or contract holder pursuant to this subdivision within 30 days of receipt of the complete claim, as defined in California Code of Regulations, title 28, section 1300.71(a)(2).

(4)

The enrollee, subscriber, or group contract holder shall be responsible for any and all premium payments accrued from the effective date of cancellation, rescission, or nonrenewal. An enrollee, subscriber, or group contract holder must pay all outstanding premiums before reinstatement.

(e)

Applicability The provisions in California Code of Regulations, title 28, sections 1300.65, 1300.65.1, 1300.65.2, 1300.65.3, 1300.65.4, and 1300.65.5 shall not apply to a plan contract offered in the Medi-Cal program (Chapters 7 (commencing with section 14000) and 8 (commencing with section 14200) of Part 3 of Division 9 of the Welfare and Institutions Code).

(f)

Format and Transmission Requirements Under this Article (1) Except for the notice required under Health and Safety Code section 1389.21, notices shall be sent by any reasonable method of transmission, including paper, electronic, or another method of transmission specifically agreed to by the enrollee, subscriber, or group contract holder. (2) The enrollee, subscriber, or group contract holder may agree to the electronic transmission of all notices under this Article, but shall not be required to opt-in to receive paper notices. For any method of transmission other than paper, the plan shall maintain a copy of the specific agreement for the method of transmission. (3) For any method of transmission other than paper, the plan shall have a tracking system to demonstrate notices were sent in compliance with the agreement between the plan and enrollee, subscriber, or group contract

holder, and applicable law. (4) Except as otherwise required under this Article, notices shall appear in at least 12-point font.

(1)

Except for the notice required under Health and Safety Code section 1389.21, notices shall be sent by any reasonable method of transmission, including paper, electronic, or another method of transmission specifically agreed to by the enrollee, subscriber, or group contract holder.

(2)

The enrollee, subscriber, or group contract holder may agree to the electronic transmission of all notices under this Article, but shall not be required to opt-in to receive paper notices. For any method of transmission other than paper, the plan shall maintain a copy of the specific agreement for the method of transmission.

(3)

For any method of transmission other than paper, the plan shall have a tracking system to demonstrate notices were sent in compliance with the agreement between the plan and enrollee, subscriber, or group contract holder, and applicable law.

(4)

Except as otherwise required under this Article, notices shall appear in at least 12-point font.