§ 1363.04. Dental services; Uniform benefits and coverage disclosure matrix

(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.

HISTORY:
Added Stats 2018 ch 933 § 2 (SB 1008), effective January 1, 2019.

§ 1363.05. Statement to be included in plan's disclosure form; Modifi- cation; Notice to enrollees

(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.

HISTORY:
Added Stats 1996 ch 1113 § 1 (SB 1581), effective January 1, 1997.

§ 1363.06. Comparative benefit matrices [Inoperative; Operative date contingent]

(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.

HISTORY:

Added Stats 2002 ch 794 § 1 (AB 1401). Amended Stats 2013 ch 441 § 1 (AB 1180), effective October 1, 2013, inoperative January 1, 2014, operative date contingent.