§ 1011. Assessment for University of California Analysis of Proposed Mandate Legislation.

(a) For the fiscal years 2004–05 and 2005–06, the Department shall assess each full service plan its share of the amount necessary to fund the Health Care Benefits Fund for that fiscal year. The amount necessary for each fiscal year will be determined by the Department and the Department of Insurance in consultation with the University of California (University) and will be based on the amount necessary to fund the actual and necessary expenses of the University, not to exceed $2 million, in the analysis of legislative health care benefit mandates for the fiscal year.

(b) The total amount owed by all full-service health plans will be 87.6% of the total amount necessary to fund the Health Care Benefits Fund. That percentage is based on the ratio between persons enrolled in full-service health care service plans and those persons enrolled in health reimbursement plans regulated by the Department of Insurance as reported in the publication "Accident & Health Covered Lives 2002" (Revised December 11, 2003) published by the Department of Insurance in May,2002.

(c) The Department shall annually calculate each full-service health plan's portion of the amount specified in subsection (b) as follows:

(1) The Department shall calculate the per-enrollee cost by dividing the amount of revenues required to be paid by all full-service health care service plans, by the total number of enrollees in this state that are enrolled in all full-service plans as of the March 31 immediately preceding the date of the assessment.

(2) The Department shall calculate each plan's annual fee by multiplying the per-enrollee cost determined pursuant to paragraph (1) of this subsection

(c) by the number of enrollees in the plan as of the March 31 immediately preceding the date of the assessment.

(d) The Department shall notify affected plans of the amount of the assessment on or before June 15 of each fiscal year and all amounts due under the assessments will be due and payable from the affected plans on or before the first day of August immediately following the date of the notice.

(e) Any amount that remains due from a plan for assessments issued for the 2002–2003 and 2003–2004 fiscal years (pursuant to Section 127662 of the California Health and Safety Code) that have not been paid to the Department by May 31,2004, will be added to the amount of the assessment due under the notice to be issued on or before June 15 of each fiscal year.

NOTE: Authority cited: Sections 1344, 1346 and 127662, Health and Safety Code. Reference: Sections 1356, 127660, 127661, 127662, 127663, 127664 and 127665, Health and Safety Code.

HISTORY:

1. New section filed 6-2-2004; operative 7-2-2004 (Register 2004, No. 23).

ARTICLE 3
Electronic Filing

Section

§ 1300.41.8. Electronic Filing.

(a) Definitions:

(1) "Electronic" means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities;

(2) "Electronic signature" means an electronic sound, symbol, or process attached to or logically associated with an electronic record, executed or adopted by a party with the intent to represent a manual signature.

(b) Notwithstanding any other provision of the regulations contained in title 28 of the CCR, plans shall file electronically any document required or permitted by law to be filed with the Department, or its designated agent, except as specified in subsection (d).

(c) Signatures:

(1) The Plan shall submit to the Director for approval, the manner, type, and format of signatures, including electronic signatures, which shall be required by the Department to be affixed to all filings.

(2) Prior to submitting electronically, the plan shall certify, under penalty of perjury, that all statements within all documents filed electronically with the Department are true and correct.

(3) Electronic signatures may be used to sign a legally effective declaration under penalty of perjury.

(4) If notarization is required, an electronic signature to be notarized must be accompanied by the electronic signature of a notary public and must include all other information to render the notarization effective under California law.

(5) The signature requirements apply to all plans, and their designated agents or representatives.

(d) The Director may grant a one-time limited exemption upon a satisfactory showing that a plan lacks the electronic capacity to satisfy the requirements for electronic filings.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1341.8, 1349, 1351, 1352, 1386 and 1387, Health and Safety Code; Sections 1633.1-1633.17, Civil Code (Uniform Electronic Transactions Act); and Section 16.5, Government Code.

HISTORY:
1. New section filed 12-27-2001 as an emergency; operative 12-27-2001 (Register 2001, No. 52). A Certificate of Compliance must be transmitted to OAL by 4-24-2002 or emergency language will be repealed by operation of law on the following day.
2. New section refiled 4-24-2002 as an emergency; operative 4-24-2002 (Register 2002, No. 17). A Certificate of Compliance must be transmitted to OAL by 8-22-2002 or emergency language will be repealed by operation of law on the following day.
3. Certificate of Compliance as to 4-24-2002 order transmitted to OAL 6-28-2002 and filed 8-8-2002 (Register 2002, No. 32).
4. New article 3 heading filed 8-12-2002; operative 9-11-2002 (Register 2002, No. 33).

CHAPTER 2
Health Care Service Plans

Article
1. Exemptions
2. Administration
3. Plan Applications and Amendments
4. Solicitors
5. Advertising and Disclosure
6. Appeals on Cancellation
7. Standards
8. Self-Policing Procedures
9. Financial Responsibility
10. Medical Surveys
11. Examinations
12. Reports
13. Books and Records
14. Miscellaneous Provisions
15. Charitable or Public Activities

HISTORY:
1. Change without regulatory effect renumbering former Title 10, Chapter 3, Subchapter 5.5 (sections 1300.43-1300.826) to new Title 28, Division 1, Chapter 1 (sections 1300.43-1300.826) filed 12-22-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 51).
2. Editorial renumbering of former chapter 1 to new chapter 2 (Register 2001, No. 50).

ARTICLE 1
Exemptions

Section
1300.43. Small Plans.
1300.43.1. New Plans.
1300.43.2. Extension for Enrollers Under Medi-Cal Program.
1300.43.3. Ambulance Plans: Conditional Exemption.
1300.43.4. Employee Welfare Benefit Plans. [Repealed]
1300.43.5. Exemption for Licensees of Insurance Commissioner. [Repealed]
1300.43.6. Moribund Plans.
1300.43.7. Student Emergency Care Arrangements.
1300.43.8. Public Agencies.
1300.43.9. Unlicensed Solicitors and Solicitor Firms.
1300.43.10. Nonprofit Retirees' Plan.
1300.43.11. Exemption for Solicitors of Nonprofit Retirees' Plans.
1300.43.12. Medi-Cal Dental Contract.
1300.43.13. Mutual Benefit Plans.
1300.43.14. Employee Assistance Programs.
1300.43.15. Foreign Plans.

§ 1300.43. Small Plans.

A health care service plan or specialized health care service plan which provides health care services or specialized health care services only to the employees of one employer, or only to the employees of employers under common ownership and control, which is administered solely by the employer, and which does not have more than five subscribers (regardless of the number of persons enrolled based upon their relationship to or dependence upon such subscribers) is exempt from all provisions of the Act and the rules thereunder, except Sections 1381, 1384 and 1385. Such plans are exempt from any rules adopted pursuant to such sections unless such rules are made specifically applicable to plans exempted under this section.

NOTE: Authority cited: Section 6, Chapter 941, Statutes 1975, and Section 1344, Health and Safety Code. Reference: Knox-Keene Health Care Service Plan Act of 1975.

HISTORY:

1. New Subchapter 5.5, Articles 1-14 (1300.43-1300.99, not consecutive) filed 6-1-76; effective thirtieth day thereafter (Register 76, No. 23).

§ 1300.43.1. New Plans.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. Amendment filed 11-30-76 as an emergency; effective upon filing (Register 76, No. 49). For prior history, see Register 76, No. 42.
2. Reinstatement of section as it existed prior to emergency amendment filed 11-30-76, by operation of Section 11422.1(b), Government Code (Register 77, No. 24).
3. Repealer filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

§ 1300.43.2. Extension for Enrollers Under Medi-Cal Program.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 8-12-76 as an emergency; effective upon filing (Register 76, No. 33).
2. Amendment filed 9-30-76 as an emergency; effective upon filing (Register 76, No. 40).
3. Amendment filed 10-12-76 as an emergency; effective upon filing. Certificate of Compliance included (Register 76, No. 42).
4. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.43.3. Ambulance Plans: Conditional Exemption.

(a) Definitions. For the purposes of this section:

(1) "Ground ambulance services" means the emergency, including advanced life support services, and non-emergency transportation of an enrollee by an individual licensed pursuant to Articles 1 and 2 of Chapter 2.5 of Division 2 of the Vehicle Code where health care services are provided to an enrollee for the duration of such transportation.

(2) "Air ambulance services" means the emergency, including advanced life support services, and non-emergency transportation of an enrollee by legally authorized air ambulance where health care services are provided to the enrollee for the duration of such transportation.

(b) A health care service plan which lawfully operates air and/or ground ambulances and provides pursuant to a plan contract only air and/or ground ambulance services to subscribers and enrollees in ambulances owned or leased by it and operated by its employees (hereinafter "Ambulance Plan") is exempted

from all provisions of the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code section 1340 et seq.) except those provisions specified herein, and subject to the condition that the Ambulance Plan complies with each of the following requirements:

(1) Every Ambulance Plan shall directly provide ground and/or air ambulance services for its enrollees throughout the Ambulance Plan's service area exclusively in ambulances owned or leased by it and operated by its employees.

(2) At the time of initial enrollment or renewal, every plan contract between an Ambulance Plan and a group or individual subscriber, and every disclosure form, evidence of coverage or plan brochure shall prominently display as a separate article the following legend, in boldface type and font size not smaller than the font size used in the general body of the document, either on the first page or on another page if referenced as "See Important Notices on Page [insert page number] Prior to Purchase" in boldface type and font size not smaller than the font size used in the general body of the document on the front page:

(A) "BEFORE YOU PURCHASE: If you are currently enrolled in a health maintenance organization (HMO) or other health insurance, the benefits provided by an Ambulance Plan may duplicate the benefits provided by your HMO or other health insurance. If you have a question regarding whether your HMO or other health insurance offers benefits for ambulance services, you should contact that other company directly."

(B) "WARNING: This Ambulance Plan is not an insurance program. It will not compensate or reimburse another ambulance company that provides emergency transportation to you or your family. This may occur when the 911 Emergency System has independently determined that another company could provide more expeditious service or is next in the rotation to receive a call. This might also occur when this Ambulance Plan is unable to perform within a medically appropriate timeframe due to a mechanical or maintenance problem or being on another call." Immediately following this warning, the Ambulance Plan shall include the words, "sign or initial here," and include a line for the subscriber's signature or initials.

(C) "COMPLAINTS: For complaints regarding this Ambulance Plan, first attempt to call the plan at [plan's toll-free telephone number]. If the Ambulance Plan fails to resolve the complaint to your satisfaction, contact the Department of Managed Health Care at 1-888-466-2219. The Department's website is *http://www.healthhelp.ca.gov*. You may obtain complaint forms and instructions online."

(D) "OPERATING UNDER CONDITIONAL EXEMPTION: This Ambulance Plan is operating pursuant to an exemption from the Knox-Keene Health Care Service Plan Act of 1975 (Health and Safety Code section 1340 et seq.)."

The Ambulance Plan may amend the wording of the legend to use its name and personal pronouns.

(3) Ambulance Plans that fail to comply with all of subsection (b)(2), including obtaining the signature or initials of subscribers next to or under the "WARNING" statement, shall be responsible for paying, reimbursing, or covering the enrollee's cost for ambulance transportation services provided by another ambulance company, less any compensation received from the subscriber's HMO, health insurer, or managed care organization, if any, and less any applicable overall annual deductible or any co-payment.

(4) An Ambulance Plan shall operate in compliance with the requirements of each local emergency medical services agency (Health and Safety Code section 1797.94) that regulates emergency services in any portion of the plan's service area and that has developed an emergency medical services plan (Health and

Safety Code section 1797.76) for an emergency medical services system (Health and Safety Code section 1797.78), implemented pursuant to the authority granted in Health and Safety Code section 1797.105(b).

(5) Ambulance Plan shall offer or sell plan contracts only to or for persons who do not live or work in the plan's service area, or to or for persons who will be in the plan's service area for a temporary period of time and for an activity covered by the Ambulance Plan, as specified in the Ambulance Plan contract. Ambulance Plans must clearly disclose that services are only available or provided within the ambulance plan's service area. Every Ambulance Plan shall comply with the following sections of the Health and Safety Code: 1360, 1363.1, 1365(a), 1365.5, 1366, subsections (a), (b), (c), (d), (e)(1), (f), (g), and (h)(1) of section 1367, 1368, 1368.01, 1368.02(b), 1373(a), 1379, 1381, subsections (a), (d), and (f) of 1384, and 1385, except that approval by the Department under section 1368(a)(1) is waived.

(6) Every Ambulance Plan shall maintain a procedure whereby enrollees, or authorized persons on their behalf, may submit grievances to the plan and in each case receive from the plan a written acknowledgement within five days of receipt of the grievance and a written response sent within 30 days of receipt of the grievance indicating what the plan will do to resolve the grievance. Both the acknowledgement and the response shall include a notice that the enrollee may contact the Department of Managed Health Care through the Department's toll-free telephone number after the grievance has been pending with the plan for at least 30 days.

(7) No Ambulance Plan contract shall require, nor shall the Ambulance Plan or any contracting provider collect, a co-payment of greater than 50 percent of an ambulance or other emergency care provider's negotiated fee-for-service rate pursuant to a contract with the ambulance service, or, in the absence of such a contract, 50 percent of the ambulance company's usual, customary, and reasonable rate (within the meaning of Business and Professions Code section 657(c)) for the particular service, or $500, whichever amount is less. An Ambulance Plan that does not impose any co-payments may impose an overall annual deductible of a specified dollar amount applicable to all covered services, provided that the deductible for an enrollee shall not exceed:

(A) 200 percent of the amount of prepaid or periodic charge for one year for the enrollee; or

(B) 200 percent of the amount of prepaid or periodic charge for one year for the family, whichever is less.

(8) Every Ambulance Plan operating ground or air ambulances shall:

(A) If operating a ground ambulance, provide proof to the Director upon request that the Ambulance Plan currently complies with Articles 1 and 2 of Chapter 2.5 of Division 2 of the California Vehicle Code, including but not limited to license and certification requirements, and with professionally recognized standards of patient care and safety in emergency medical services and transport.

(B) If operating an air ambulance, provide proof to the Director upon request that the Ambulance Plan currently complies with regulations established by the Federal Aviation Administration and with professionally recognized standards of patient care and safety in emergency medical air services and transport.

(9) Every Ambulance Plan operating air ambulances shall comply with all applicable federal, state, and local laws. Ambulance plans may use the "Guidelines for Air Medical Crew Education," revised and copyrighted 2004 and published by the Association of Air Medical Services, when determining the scope of their educational programs for purposes of training air crews.

(10) No Ambulance Plan shall receive prepaid or periodic charges pursuant to its plan contract for more than one year in advance.

(11) Every Ambulance Plan shall deliver:

(A) To each prospective subscriber, upon presenting a plan contract for offer or sale, a disclosure form, combined disclosure form and evidence of coverage, or copy of its plan contract,

(B) Annually, to each subscriber a copy of its plan contract and evidence of coverage, and

(C) To each subscriber and enrollee a membership card or other form of identification easily carried by the subscriber or enrollee that indicates that the subscriber or enrollee is an Ambulance Plan member and that lists phone numbers and other instructions for activating ambulance transport.

(12) The plan contract and any disclosure form and evidence of coverage used by the Ambulance Plan, shall comply with Health and Safety Code sections 1362 and 1363 and the rules of the Director of the Department of Managed Health Care pursuant to and including sections 1300.63, 1300.63.1, 1300.63.2, and 1300.63.3 of title 28.

(13) Every Ambulance Plan must maintain documentation demonstrating compliance with all the conditions of the exemption and provide to the Department of Managed Health Care all or any part of such documentation as required by the Department within 30 days of request.

(14) No Ambulance Plan shall purport to rely on the exemption pursuant to this section if the Director has issued an order of termination pursuant to subsection (c).

(c) An Ambulance Plan's exemption pursuant to this section may be terminated by order of the Director, upon a determination that such action is in the public interest and for the protection of enrollees, or for any of the following reasons:

(1) The services of the Ambulance Plan are not accessible to enrollees.

(2) The Ambulance Plan, or a person employed by the Ambulance Plan, has failed to comply with licensing or certification requirements imposed by law.

(3) The Ambulance Plan is operating in an unsafe, unfair, unreasonable or discriminatory manner as to its enrollees or as to its enrollment practices.

(4) The financial condition of the Ambulance Plan is such that its continued operation will constitute a substantial risk to its subscribers and enrollees.

(5) The Ambulance Plan has engaged in conduct proscribed by the Health and Safety Code section 1386(b), subsections (5), (6), (7), (8), (9), (10), (11), or (14).

(6) The Ambulance Plan has been or is subject to a limitation, requirement, condition, adverse action, or disciplinary action taken by a licensing agency or an emergency medical services agency that would materially impair its ability to perform its plan contracts or constitute or result in a violation of the provisions of this section or of the referenced provisions of the Act.

(7) The Ambulance Plan has violated any condition of this exemption.

(d) An Ambulance Plan's exemption pursuant to this section shall terminate automatically by operation of law upon the plan's failure to comply with any of the conditions set forth in subsection (b).

(e) An Ambulance Plan whose exemption has been terminated by operation of law because of failure to comply with the conditions set forth in subsection (b) or by order of the Director under subsection (c) shall be in violation of section 1349 of the Health and Safety Code and shall be subject to all of the provisions of the Knox-Keene Health Care Service Plan Act of 1975, including but not limited to the provisions relating to discipline and enforcement procedures.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343(b), Health and Safety Code.

HISTORY:
1. New section filed 9-30-76 as an emergency; effective upon filing (Register 76, No. 40).
2. Certificate of Compliance filed 1-27-77 (Register 77, No. 5).
3. Amendment filed 4-2-79; effective thirtieth day thereafter (Register 79, No. 14).
4. Editorial correction of subsections (a)7.f. and (b)(6) (Register 80, No. 4).
5. Change without regulatory effect amending section filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
6. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
7. Change without regulatory effect updating title references in Notice filed 12-22-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 51).
8. Change without regulatory effect amending subsection (a)—form filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).
9. Repealer and new section heading and section and amendment of Note filed 7-24-2003; operative 8-23-2003 (Register 2003, No. 30).
10. Amendment of subsections (b)(2)(C), (b)(5) and (b)(9) filed 5-7-2014; operative 7-1-2014 (Register 2014, No. 19).

§ 1300.43.4. Employee Welfare Benefit Plans. [Repealed]

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:
1. Amendment filed 3-6-78 as an emergency; designated effective 3-6-78 (Register 78, No. 10). For prior history, see Register 77, No. 36.
2. Certificate of Compliance filed 4-20-78 (Register 78, No. 16).
3. Amendment filed 8-14-78 as an emergency; designated effective 8-15-78 (Register 78, No. 33).
4. Certificate of Compliance filed 11-8-78 (Register 78, No. 45).
5. Repealer filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).

§ 1300.43.5. Exemption for Licensees of Insurance Commissioner. [Repealed]

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:
1. New section filed 12-20-77 as an emergency; effective upon filing (Register 77, No. 52).
2. Certificate of Compliance filed 4-4-78 (Register 78, No. 14).
3. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.43.6. Moribund Plans.

A health care service plan which is a general acute care hospital whose business as a plan is limited to providing, administering, or otherwise arranging for the provision of health care services to members of one moribund group of not more than 250 members is exempted from the provisions of the Knox-Keene Health Care Service Plan Act of 1975, subject to each of the following conditions:

(a) That such plan is licensed as a health facility pursuant to Chapter 2 (commencing with Section 1250) of the Health and Safety Code, and is not insolvent.

(b) That such plan has not accepted any new members for the last twenty years and does not accept any new members for the duration of this exemption.

(c) That such plan receives prepaid or periodic charges, if any, from members of such group in an amount not exceeding $5 per member per month and has

received no substantial payment or transfer of property from or on behalf of such contracting group during the last twenty years.

(d) That such plan derives not more than one-half of one percent of its annual income from prepaid or periodic charges paid by or on behalf of members of such group, and has a minimum net worth of $15,000,000 based upon its most recent certified financial statements (prepared as of a date within the preceding 15 months).

(e) That such plan establish and maintain a grievance procedure substantially complying with Section 1300.68.

(f) That such plan deliver to each subscriber and enrollee within 60 days of the adoption of this section, and thereafter to any subscriber or enrollee upon request, 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 PROVIDED BY RULE OF THE DIRECTOR OF THE DEPARTMENT OF MANAGED HEALTH CARE OF THE STATE OF CALIFORNIA."

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 6-13-78 as an emergency; effective upon filing (Register 78, No. 24).
2. Certificate of Compliance filed 8-18-78 (Register 78, No. 33).
3. Editorial correction of subsection (f) (Register 95, No. 12).
4. Change without regulatory effect amending subsection (f) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
5. Change without regulatory effect amending subsection (f) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.43.7. Student Emergency Care Arrangements.

There is exempted from the provisions of the Act any nonprofit corporation or association all of whose members are licensed physicians and which is a health care service plan as defined by subdivision (f) of Section 1345 only by reason of health care service plan contracts with one or more colleges or universities pursuant to which such nonprofit corporation or association furnishes or arranges only emergency health care services and health care services ancillary thereto to members of the student body of, employees of, and visitors to such colleges or universities, provided that each of the following conditions is met:

(a) At least 95 percent of the cost of health care services furnished pursuant to such contracts is furnished by employees or members of such nonprofit corporation or association or contracting providers.

(b) All services furnished by members pursuant to such contracts are furnished pursuant to provider contracts which comply with Section 1379 of the Act.

NOTE: Authority cited: Section 1343, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 8-22-78; effective thirtieth day thereafter (Register 78, No. 34).

§ 1300.43.8. Public Agencies.

NOTE: Authority cited: Section 1343, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:
1. New section filed 9-27-79; effective thirtieth day thereafter (Register 79, No. 39).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.43.9. Unlicensed Solicitors and Solicitor Firms.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:
1. New section filed 11-9-79 as an emergency; effective upon filing (Register 79, No. 45). A Certificate of Compliance must be filed within 120 days or emergency language will be repealed on 3-9-80.
2. Repealed by operation of Section 11422.1(c), Government Code (Register 80, No. 24).

§ 1300.43.10. Nonprofit Retirees' Plan.

A health care service plan which was registered under the Knox-Mills Health Plan Act as in effect on June 30, 1976, whose activity as a plan is limited to reimbursing part or all of the cost of health care services as a supplement to Medicare (Parts A and B) to persons who were retired from professions associated with higher learning after having been employed therein for not less than 10 cumulative years and such persons' spouses, providing all such persons are enrolled in Medicare, is exempted from the provisions of Section 1349 of the Knox-Keene Health Care Service Plan Act of 1975, subject to each of the following conditions:

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

(b) That such plan is exempted from federal income tax as an organization described in Section 501(c)(3) of the Internal Revenue Code and from state income tax on similar grounds.

(c) That such plan is a charitable corporation subject to, and in compliance with, the Uniform Supervision of Trustees for Charitable Purposes Act.

(d) That such plan does not directly provide any health care services through entity-owned or contracting health facilities or providers.

(e) That such plan has a tangible net equity within the meaning of Section 1300.76(b) of not less than $300,000, including liquid tangible assets in an amount not less than $300,000, based upon its most recent certified financial statement (prepared as of a date within the preceding 15 months and such other date as may be requested by the Director pursuant to Section 1384 of the Act) and its most recent quarterly and monthly uncertified 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 person enrolled in excess of 400; provided that the maximum number of enrollees shall not exceed 500.

(f) That not more than 15% of the total charges paid by or on behalf of subscribers or enrollees for enrollment in, or for health care benefits from, such plan is expended for administrative costs, including all costs of solicitation and enrollment; except that such plan may expend additional sums of money for administrative costs excluding costs of solicitation and enrollment provided that such money is not derived from revenue obtained from subscribers or enrollees.

(g) That such plan issues a uniform health care service plan contract to all subscribers

(1) which provides, except for a permissible calendar year deductible not to exceed $100 per enrollee, full coverage for all copayments and deductibles relating to allowable charges under Medicare (Parts A and B) for all health care services covered by Medicare (Parts A and B) pursuant to Title XVIII of the Social Security Act as amended, and not less than 50% of the reasonable charges for each health care service which is not covered by Medicare but is covered by such plan; provided, however, that such coverage may be subject to a lifetime limitation allowing not less than $300,000 of benefits per lifetime and

(2) which provides that an enrollment or subscription may not be cancelled except upon grounds complying with Section 1365 of the Act.

(h) That such plan provides to each subscriber 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 and which also states, if such is the case, that such contract does not cover, and that subscribers and enrollees will be solely liable for,

(1) any charges in excess of allowable charges under Medicare with respect to health care services covered by Medicare,

(2) any charges in excess of reasonable charges for any health care services covered by such plan but not covered by Medicare and any copayments related to such health care services, and

(3) any permissible plan deductible.

(i) That no less than 75% of the officers and of the directors of such corporation are persons who are retired from the professions associated with higher learning after having been employed therein not less than 10 cumulative years, are enrolled in Medicare, and are enrolled in such plan subject to terms and conditions no more favorable than any other enrollee, and that no officer or director receives any compensation from such corporation.

(j) That such plan solicits enrollments or subscriptions in this state only through persons who are officers or employees of such plan.

(k) That such plan establishes and maintains a grievance procedure substantially complying with Section 1300.68 of these rules.

(*l*) That such plan not represent any contract of such plan as a Medicare supplement contract and discloses to each prospective subscriber and enrollee when presenting any information regarding the plan, and again at the time of application, the following written notice:

> "THE HEALTH PLAN CONTRACT OFFERED BY (Name of plan) DOES NOT MEET THE REQUIREMENTS FOR CERTIFICATION AS A MEDICARE SUPPLEMENT CONTRACT PURSUANT TO APPLICABLE STATE OR FEDERAL LAW, AND HAS NOT BEEN CERTIFIED. PERSONS DESIRING INFORMATION REGARDING CERTIFIED MEDICARE SUPPLEMENT COVERAGE SHOULD CONTACT THEIR LOCAL MEDICARE OFFICE."

(m) That such plan delivers to each subscriber and enrollee within 60 days of the adoption 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."

(n) That such plan provides 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) and (g) of this section.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:
1. New section filed 11-21-79; effective thirtieth day thereafter (Register 79, No. 47).
2. Amendment filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).
3. Change without regulatory effect amending subsections (e), (m) and (n) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. Change without regulatory effect amending subsection (m) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.43.11. Exemption for Solicitors of Nonprofit Retirees' Plans.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code.

Reference: Section 1343, Health and Safety Code.

HISTORY:
1. New section filed 11-21-79; effective thirtieth day thereafter (Register 79, No. 47).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.43.12. Medi-Cal Dental Contract.

The contract of the Department of Health Services which is entered as the result of successful bidding in response to said Department's request for proposal and which requires the contractor to provide only dental benefits for the state's Medi-Cal beneficiaries pursuant to Section 14104.3 of the Welfare and Institutions Code and incorporates the terms and provisions set forth in the request for proposal, is exempt from the provisions of the Act, if the successful bidder ("entity") is not already licensed under the Act, for the period indicated below, subject to each of the following:

(a) The entity engages in no activities as a plan other than those pursuant to the Medi-Cal dental contract described above or pursuant to a separate exemption in the Act or these rules.

(b) The entity properly files an application for licensure under the Act, as required by Sections 1351 and 1356 of the Act, prior to executing the contract referred to above, except that the information contained in the application submitted at the time of filing need not include information not required to be provided to the Department of Health Services pursuant to its request for proposal, so long as the additional information required by Section 1351 of the Act or by the application form provided by the Director is filed as an amendment to the license application within six weeks of the date of execution of the contract referred to above, or any longer period as the Director by order may allow under the Director's waiver authority set forth in Section 1344(a) of the Act.

(c) The entity reasonably pursues the completion of its application and compliance with the provisions of the Act and applicable rules thereunder.

(d) The entity, for the duration of the exemption provided by this section, shall be subject to the provisions of Sections 1351.1, 1381, 1384, and 1385 of the Act, and may be examined by the Director in the manner and subject to the arrangements provided in Section 1382 of the Act.

(e) The exemption provided by this section shall be effective only until the earlier of

(1) final action by the Director on the application, or

(2) the expiration of nine months after execution of the contract referred to above, except that said nine month period may be waived by order of the Director for any additional one month periods under the Director's waiver authority set forth in Section 1344(a) of the Act.

(f) For the purposes of this section, the term "order" means a written waiver applicable to a specific case issued by the Director pursuant to Section 1344(a) of the Act.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Sections 1343, 1344, 1351, 1351.1, 1353, 1356, 1381, 1382, 1384 and 1385, Health and Safety Code.

HISTORY:

1. New section filed 3-9-84; effective thirtieth day thereafter (Register 84, No. 10).
2. Change without regulatory effect amending subsections (b) and (d)-(f) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 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.

(*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.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Sections 1343 and 1344, Health and Safety Code.

HISTORY:

1. New section filed 6-5-84; effective thirtieth day thereafter (Register 84, No. 23).
2. Change without regulatory effect amending subsections (j) and (q)-(r) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
3. Change without regulatory effect amending subsection (q) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.43.14. Employee Assistance Programs.

(a) A health care service plan which, pursuant to a contract with an employer, labor union or licensing board within the Department of Consumer Affairs, consults with employees, members of their families or licensees of such board to identify their health, mental health, alcohol and substance abuse problems and refer them to health care providers and other community resources for counseling, therapy or treatment, is exempt from the provisions of the Act (other than Sections 1360, 1360.1, 1368 and 1381, relating to advertising, client grievance procedures and the inspection of records by the Director) if the plan complies with each of the following provisions, and the contracts of a licensed health care service plan are exempt from the provisions of the Act if they comply with each of the following provisions:

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

(2) The purpose of the contract, insofar as it relates to the provision of services to clients is either

(A) to maintain or improve employee efficiency through identification and referrals for counseling, treatment or therapy, in connection with personal problems affecting employee performance and the contract does not provide for counseling, treatment or therapy with respect to health, mental health, alcohol or substance abuse problems or

(B) to identify alcohol and substance abuse problems or mental health or health problems of DCA licensees and refer them to appropriate health care providers or organizations for treatment, and the plan does not provide for counseling, treatment or therapy with respect to health, mental health, alcohol or substance abuse problems.

(3) No client or member of his or her family, directly or indirectly shall pay any prepaid or periodic charge under the contract or pay any copayment, fee or other charge for any service rendered under the contract in connection with a health, mental health, alcohol or substance abuse problem. The payment of regular union dues by an employee, a license fee by a DCA licensee, or of a benefit payment by an employer on behalf of an employee and members of the employee's family which does not affect the employee's compensation or other benefits is not a "prepaid or periodic charge" for the purpose of this subsection.

(4) If such plan, its employees or contracting consultants, or an affiliate of any of the foregoing, has a financial interest in referrals made under the

contract in connection with a health, mental health, alcohol or substance abuse problem, such person prior to making any such referral shall disclose to the contracting employer, union or state licensing agency and to the person who is referred, the existence of such financial interest; provided that neither the plan nor its employees shall receive any payment, fee or commission directly or indirectly from any person to whom an employee, licensee or family member is referred for counseling, treatment or therapy. The disclosure requirement to the employer may be a single blanket disclosure provided it identifies the providers to which referrals will be made and identifies the financial interest involved.

(5) The number of sessions with any client under the contract shall not exceed 3 within any six month period.

(6) Except as otherwise provided in Division 2 (commencing with Section 500) of the Business and Professions Code, the plan shall maintain a record for a period of not less than two years of each session with a client concerning a health, mental health, alcohol or substance abuse problem, and each consultation excluded from the definition of "session." The record shall include the name of or identifier for the client, the date and purpose of the session and the outcome if any, including the name of the provider to which the client was referred. The employee assistance program contracts and the records specified pursuant to subparagraph (6) shall be available for inspection by the Director as provided in Section 1381 of the Act.

(7) The plan and the personnel, facilities and equipment of the plan, including that employed under contract, shall be licensed or certified when required by applicable law and persons engaged in identification and referral who are not licensed under Division 2 of the Business and Professions Code shall be certified by any of the following organizations:

(A) Any organization accredited by the National Commission for Accreditation of Alcohol/Drug Abuse Counselors' Credentialing Bodies, Inc.

(B) Alcoholism Council of California.

(C) California Association of Alcoholism and Drug Abuse Counselors.

(D) Association of Labor-Management Administrators and Consultants on Alcoholism.

(8) Unless the plan is licensed under the Act, no prepaid fees shall be collected more than 45 days in advance.

(b) For the purposes of this section the following definitions apply:

(1) "Client" means the employee, the employee's family member, the DCA licensee or other person eligible for the services provided under the plan contract.

(2) "DCA licensee" means a licensee of the Department of Consumer Affairs.

(3) "Session" means any in-person or telephone consultation with the client in connection with the client's health, mental health, alcohol or substance abuse problems, excluding a consultation that occurs in an acute emergency situation, a consultation after referral for motivation or re-referral or a consultation due to a management, state licensing agency or union request for information or assessment regarding work performance issues.

(c) The notice specified in subsection (a)(1) shall be in the following form and contain the information specified below:

DEPARTMENT OF MANAGED HEALTH CARE
STATE OF CALIFORNIA

NOTICE OF EMPLOYEE ASSISTANCE PROGRAM
EXEMPTION RULE 1300.43.14,
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 1300.43.14 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. Fictitious names used in connection with the operation of employee assistance programs (if none, so specify):

_____

4. Identify each location at which the plan maintains records subject to inspection by the Director under Rule 1300.43.14(a)(6) (if space is insufficient, continue on separate sheet):

_____

_____

_____

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

6. The person/entity filing this notice declares hereby that it is in compliance with the provisions of Rule 1300.43.14, 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 _____ on _____
(City and State) (Date)

_____
(Signature)

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:
1. New section filed 6-12-87; operative 6-12-87 (Register 87, No. 28).
2. Change without regulatory effect amending section filed 4-4-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 14).
3. Change without regulatory effect amending subsections (a)-(a)(1), (a)(6) and (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
4. Change without regulatory effect amending subsection (c)—form filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 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.

(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 _____ on _____ 19_____

_____
(Signature)

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1343, Health and Safety Code.

HISTORY:

1. New section filed 9-8-88; operative 10-8-88 (Register 88, No. 38).
2. Change without regulatory effect amending subsections (a)(4) and (b) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
3. Change without regulatory effect amending subsection (b)—form filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

ARTICLE 2
Administration

Section

§ 1300.44. Interpretive Opinions.

NOTE: Authority cited: Section 1344, Health and Safety Code.

HISTORY:

1. Repealer filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

§ 1300.44.1. Application for Exemption from Rule.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1344, 1351 and 1352, Health and Safety Code.

HISTORY:

1. Amendment of subsection (b) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Repealer filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).

§ 1300.45. Definitions.

In addition to the definitions contained in Section 1345 of the Act, the following definitions apply to the interpretation of these rules and the Act:

(a) "Act" means the Knox-Keene Health Care Service Plan Act of 1975.

(b) "Advertisement" includes the disclosure form required pursuant to Section 1363 of the Act.

(c) (1) An "affiliate" of a person is a person controlled by, under common control with, or controlling such person.

(2) A person's relationship with another person is that of an "affiliated person" if such person is, as to such other person, a director, trustee or a member of its executive committee or other governing board or committee, or that of an officer or general partner, or holds any other position involving responsibility and authority similar to that of a principal officer or general partner; or who is the holder of 5% or more of its outstanding equity securities; or who has any such relationship with an affiliate of such person. An affiliate is also an affiliated person.

(d) The term "control" (including the terms "controlling," "controlled by" and "under common control with") means the possession, direct or indirect, of the power to direct or cause the direction of the management and policies of a person, whether through the ownership of voting shares, debt, by contract, or otherwise.

(e) The term "certified" or "audited," when used in regard to financial statements, means examined and reported upon with an opinion expressed by an independent public or certified public accountant.

(f) "Code" means the California Health and Safety Code.

(g) "Copayment" means an additional fee charged to a subscriber or enrollee which is approved by the Director, provided for in the plan contract and disclosed in the evidence of coverage or the disclosure form used as the evidence of coverage.

(h) "Department" means the California Department of Managed Health Care.

(i) "Facility" means

(1) any premises owned, leased, used or operated directly or indirectly by or for the benefit of a plan or any affiliate thereof, and

(2) any premises maintained by a provider to provide services on behalf of a plan.

(j) "Family unit" means a unit composed of a subscriber and each person whose eligibility for benefits is based upon such person's relationship with, or dependency upon, such subscriber.

(k) "Hospital based plan" means a health care service plan which owns, operates or is affiliated with a hospital as an integral part of delivering health care services.

(*l*) "Material": A factor is "material" with respect to a matter if it is one to which a reasonable person would attach importance in determining the action to be taken upon the matter.

(m) "Primary care physician" means a physician who has the responsibility for providing initial and primary care to patients, for maintaining the continuity of patient care, or for initiating referral for specialist care. A primary care physician may be either a physician who has limited his practice of medicine to general practice or who is a board-certified or board-eligible internist, pediatrician, obstetrician-gynecologist, or family practitioner.

(n) "Principal creditor" means

(1) a person who has loaned funds to another for the operation of such other person's business, and

(2) a person who has, directly or indirectly, 20 percent or more of the outstanding debts of a person.

(o) "Principal officer" means a president, vice-president, secretary, treasurer or chairman of the board of a corporation, a sole proprietor, the managing general partner of a partnership, or a person having similar responsibilities or functions.

(p) "Surcharge" means an additional fee which is charged to a subscriber or enrollee for a covered service but which is not approved by the Director,

provided for in the plan contract and disclosed in the evidence of coverage or the disclosure form used as the evidence of coverage.

(q) The term "generally accepted accounting principles," when used in regard to financial statements, assets, liabilities and other accounting items, means generally accepted accounting principles as used by business enterprises organized for profit. Accordingly, Financial Accounting Standards Board statements, Accounting Principles Board opinions, accounting research bulletins and other authoritative pronouncements of the accounting profession should be applied in determining generally accepted accounting principles unless such statements, opinions, bulletins and pronouncements are inapplicable. Section 510.05 of the AICPA Professional Standards, in and of itself, shall not be sufficient reason for determining inapplicability of statements, opinions, bulletins and pronouncements.

NOTE: Authority cited: Sections 1344 and 1352, Health and Safety Code. Reference: Sections 1351, 1351.1 and 1352, Health and Safety Code.

HISTORY:

1. Amendment of subsection (c) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. New subsection (q) filed 4-27-79; effective thirtieth day thereafter (Register 79, No. 17).
3. Amendment of subsection (e) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
4. Amendment of subsection (c) filed 12-17-85; effective thirtieth day thereafter (Register 85, No. 51).
5. Change without regulatory effect amending subsections (g)-(h) and (p) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
6. Change without regulatory effect amending subsection (h) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.46. Prohibition of Bonuses or Gratuities in Solicitations.

No person subject to the provisions of the Act shall offer or otherwise distribute any bonus or gratuity to potential subscribers for the purpose of inducing enrollment or to existing subscribers for the purpose of inducing the continuation of enrollment.

§ 1300.47. Advisory Committee on Managed Health Care.

Each member of the Advisory Committee on Managed Health Care shall file with the Director a statement setting forth the following:

(a) The firm with which such member is employed or affiliated and the capacity in which employed or affiliated.

(b) Whether such firm is a health care service plan or solicitor firm under the Act or is a provider, or a fiscal intermediary for a plan, or furnishing services, goods or facilities to any plan, solicitor firm or provider.

(c) Whether such member has any financial interest in any firm specified in (b) or receives compensation from such firm.

(d) The name of each plan in which the member is enrolled, or has been enrolled during the preceding 10 years.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference:

Section 1347, Health and Safety Code.

HISTORY:

1. Amendment filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Change without regulatory effect amending section heading and first paragraph filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).
3. Change without regulatory effect amending section heading and first paragraph filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

ARTICLE 3
Plan Applications and Amendments

§ 1300.49. General Licensure Requirements.

(a) Definitions

As used in this section:

(1) "Global risk" means the acceptance of a prepaid or periodic charge from or on behalf of enrollees in return for the assumption of both professional and institutional risk.

(2) "Institutional risk" means the assumption of the cost for the provision of hospital inpatient, hospital outpatient, or hospital ancillary services to subscribers or enrollees undertaken by a person, other than services performed pursuant to the person's own license under section 1253 of the Health and Safety Code, in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(3) "Limited health care service plan" means a person with a health care service plan license with waivers issued by the Department or its predecessor prior to January 1,2000 for the provision of, or the arranging, payment, or reimbursement for the provision of, health care services to subscribers or enrollees of another health care service plan under a contract or other arrangement whereby the person assumes both professional and institutional risk.

(4) "Prepaid or periodic charge" for the purposes of this section means any amount of compensation, either at the start or end of a predetermined period, for assuming the risk, or arranging for others to assume the risk, of delivering or arranging for the delivery of the contracted-for health care services for subscribers or enrollees that may be fixed either in amount or percentage of savings or losses in which the entity shares.

(5) "Professional risk" means the assumption of the cost for the provision of physician, ancillary, or pharmacy services undertaken by physicians or other licensed or certified providers to subscribers or enrollees in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(6) "Restricted health care service plan" means a person with a health care service plan license issued by the Department for the provision of, or the arranging, payment, or reimbursement for the provision of, health care services to subscribers or enrollees of another full service or specialized health care service plan under a contract or other arrangement whereby the person assumes both professional and institutional risk but does not directly market, solicit, or sell health care service plan contracts.

(b) (1) Any person who assumes global risk shall obtain a license to operate a health care service plan pursuant to section 1349 of the Health and Safety Code.

(2) Pursuant to section 1343 of the Health and Safety Code, the Director shall grant an exemption from this section to any person upon review and a finding that the action is in the public interest and not detrimental to the protection of subscribers, enrollees or persons regulated under the Knox-Keene Act. A person requesting an exemption shall submit the following information for consideration by the Director:

(A) The filing of Exhibit GG, Financial Viability, and Exhibit HH, Projected Financial Viability, of the application for licensure, pursuant to rule 1300.51 of this title. The Exhibits shall include current financial statements and projected changes that have or are expected to occur upon the assumption of global risk. A person that already files audited financial statements with the Department may request an exemption from filing Exhibit GG;

(B) The total percentage of annualized income of institutional risk the person will assume and how it will be assumed;

(C) The contract(s) for the assumption of global risk;

(D) The estimated number of subscribers and enrollees for whom the person will provide health care services;

(E) The geographic service area(s) under the global risk arrangement(s) in which the person intends to operate; and

(F) Any other information the person believes is appropriate or relevant for the Director to consider when reviewing the exemption request.

(G) Persons requesting an exemption shall submit the request to the following address: OPLInquiries@dmhc.ca.gov or submit a hard copy to the Department of Managed Health Care, ATTN: Office of Plan Licensing, 980 Ninth Street, 5th Floor, Sacramento, CA 95814.

(3) When reviewing the information submitted under subdivision (b)(2) of this regulation, the Director shall consider the following criteria:

(A) The person's portion of contracted global risk when compared to the person's overall business;

(B) The portion of market share the person assumes for global risk in the geographical region compared to the market share assumed by other persons within the region, and whether disruption will occur in the marketplace if the person fails to maintain financial solvency;

(C) The financial capacity to assume a portion of global risk without jeopardizing enrollee access to basic health care services in the geographical region;

(D) The potential impact on the health care marketplace in the geographical region in which the person operates, including the impact on contracted institutional and professional providers, if the person is unable to maintain financial solvency; and,

(E) The issuance of an exemption will not negatively impact public interest or protection of the public, subscribers, enrollees, or persons subject to the Knox-Keene Act, if the person assumes global risk.

(4) The Director shall issue the decision on the request for exemption from licensure under this section within 30 days of receipt of the request by the Department.

(c) (1) (A) A restricted health care service plan may contract with and accept global risk from only a full service health care service plan or a specialized health care service plan to provide or arrange health care services for that entity's subscribers or enrollees.

(B) A restricted health care service plan may not market, solicit, or sell health care service plan contracts to individual members of the public, employers, or any other person or group.

(2) An applicant seeking licensure as a restricted health care service plan shall file:

(A) An application for licensure in accordance with section 1351 of the Health and Safety Code and rule 1300.51 of this title. The application for licensure shall include all exhibit types, and within each exhibit as relevant, shall specify the functions for which the applicant restricted health care service plan will be responsible and which functions shall be the responsibility of the full service health care service plan or specialized health care service plan with which the restricted health care service plan contracts.

(B) All contractual agreements between the applicant restricted health care service plan and the full service health care service plan, or specialized health care service plan, with which the applicant restricted health care service plan contracts.

(C) A Restricted Health Care Service Plan Responsibility Statement, dated November,2018, hereby incorporated by reference, describing the obligations of both the applicant restricted health care service plan and the full service health care service plan or specialized health care service plan with which the applicant restricted health care service plan contracts. The Restricted Health Care Service Plan Responsibility Statement shall disclose all requirements of the Knox-Keene Act and this title which remain the sole responsibility of the full service health care service plan or specialized health care service plan and which health care services will be the responsibility of the applicant restricted health care service plan. This statement must be signed by both the full service health care service plan or specialized health care service plan and the applicant restricted health care service plan.

(3) Pursuant to the network adequacy requirements of the Knox-Keene Act and this chapter, including those requirements set forth in sections 1367, 1367.03, and 1375.9 of the Health and Safety Code, as well as rules 1300.51, 1300.67.2, 1300.67.2.1, and 1300.67.2.2 of this title, the applicant restricted health care service plan shall maintain its own contracted provider network that ensures adequate access to all health care services for which it maintains responsibility pursuant to the Restricted Health Care Service Plan Responsibility Statement.

(4) Restricted health care service plans licensed by the Department as of July 1,2019 may continue to engage in business as restricted health care service plans under this section.

(d) Limited health care service plans licensed by the Department or its predecessor as of July 1,2019 may continue to engage in business as limited health care service plans.

(e) This section shall apply only to contracts issued, amended, or renewed on or after July 1,2019.

NOTE: Authority cited: Sections 1344 and 1349, Health and Safety Code. Reference: Sections 1343.5, 1345, 1349, 1351 and 1375.1, Health and Safety Code.

HISTORY:

1. New section filed 3-5-2019; operative 7-1-2019 (Register 2019, No. 10).

§ 1300.50. Notice of Intention to Apply for Plan License.

NOTE: Authority cited: Section 1344, Health and Safety Code.

HISTORY:
1. Repealer filed 6-29-84; effective thirtieth day thereafter (Register 84, No. 26).