§ 1300.57.1. Solicitor Firm Application by Person Not Licensed by Insurance Commissioner.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1357, Health and Safety Code.

HISTORY:
1. Amendment filed4-27-79; effective thirtieth day thereafter (Register 79, No. 17).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.57.2. Amendment to Solicitor Firm Application.

HISTORY:
1. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.57.3. Fees Payable by Licensed Insurance Agents and Brokers.

HISTORY:
1. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.57.4. Solicitor Financial Records Authorization.

NOTE: Authority cited: Sections 1343 and 1344, Health and Safety Code. Reference: Section 1357, Health and Safety Code.

HISTORY:
1. New section filed 11-9-77 as an emergency; effective upon filing (Register 77, No. 46).
2. Certificate of Compliance filed 2-6-78 (Register 78, No. 6).
3. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.59. Plan Assurances Prior to Solicitation.

Prior to allowing any person to engage in acts of solicitation on its behalf, each plan shall reasonably assure itself that such person has sufficient knowledge of its organization, procedures, plan contracts, and the provisions of the Act and these rules to do so lawfully.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1359, Health and Safety Code.

HISTORY:
1. Repealer and new section filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.59.1. Examination Fee.

HISTORY:
1. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.59.2. Waiver of Examination Requirements.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1359, Health and Safety Code.

HISTORY:
1. Amendment filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

ARTICLE 5
Advertising and Disclosure

Section

§ 1300.61. Filing of Advertising and Disclosure Forms.

(a) Two copies of a proposed advertisement shall be filed. An advertisement is "filed" within the meaning of Section 1361 of the Act when a true copy thereof, accurately showing the final appearance of the advertisement, is received. To minimize the expense of changes in advertising copy, it may be submitted in draft form for preliminary review subject to the later filing of a proof or final copy, and the later filing of a proof or final copy may be waived when the draft copy is presented in a manner reasonably representing the final appearance of the advertisement. The text of audio or audio/visual advertising should indicate any directions for presentation, including voice qualities and the juxtaposition of the visual materials with the text.

(b) The Director will not issue letters of non disapproval of advertising. If the person submitting the advertisement requests an order shortening the 30-day waiting period under Section 1361 of the Act, such order will be issued when an appropriate showing of the need therefor is made.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1361, Health and Safety Code.

HISTORY:
1. Change without regulatory effect amending subsection (b) and adding Note filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.61.1. Exempt Advertising.

HISTORY:
1. Repealer filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).

§ 1300.61.3. Deceptive Advertising.

Without limitation upon the meaning of subdivision (a) of Section 1352.1 and subdivisions (a) and (c) of Section 1361 of the Act, an advertisement or other consumer information is untrue, misleading or deceptive if:

(a) It represents that reimbursement is provided in full for the charge for services, unless the payment by the plan fully satisfies the liability to the provider.

(b) It represents that reimbursement is provided for the customary charges for services, unless the actual experience of the plan is that there is no balance billed for covered services.

(c) It represents that the plan, solicitor firm or solicitor or any provider or other person associated therewith is licensed or regulated by the Department of Managed Health Care or other governmental agency, unless such statement is required by law or regulation or unless such statement is accompanied by a satisfactory statement which counters any inference that such licensing or regulation is an assurance of financial soundness or the quality or extent of services. The phrase "a federally qualified health maintenance organization" and equivalent terms shall not be deemed deceptive advertising when used to refer to an organization which is so qualified under the Health Maintenance Organization Act of 1973. The display, on a plan contract which supplements Medicare with hospital or medical coverage, of the particular emblem approved by the federal Department of Health and Human Services and indicating that such contract meets the certification requirements of 42 U.S.C. 1395ss and the regulations of the Health Care Financing Administration thereunder, or, in lieu of such emblem, of such information, if any, regarding certification as may be approved in writing as to form and content by the Director, shall not be deemed deceptive when (1) the Director has found that such contract complies with the provisions of the Act and these rules and by written notification has authorized the plan to so display such emblem or, in lieu of such emblem, such expressly approved information, if any, regarding certification and has not revoked such authorization, and (2) such contract, and any related disclosure form, evidence of coverage, printed material, and advertising, contains no untrue information regarding the emblem and does not otherwise violate this subsection.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1352.1, 1360 and 1361, Health and Safety Code.

HISTORY:

1. New subsection (c) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).
3. Change without regulatory effect amending subsection (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) filed 11-21-2002 pursuant to section 100, title 1, California Code of Regulations (Register 2002, No. 47).

§ 1300.63. Disclosure Form.

(a) The disclosure form required under subdivision (a) of Section 1363 of the Act shall conform to the following requirements.

(1) The text shall be printed in at least 10-point block type. Titles and captions shall be in at least 12-point to 15-point bold face type.

(2) It shall be written in clear, concise, easily understood language.

(3) It should relate to one form of plan contract; however, disclosure forms offering alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract.

(4) It shall be presented in an easily readable format.

(b) The disclosure form shall be arranged and captioned in the following manner, except as may otherwise be permitted by the Director.

(1) The name of the plan and, if necessary, a designation of the plan contract described in the form.

(2) The title of the form (e.g., "disclosure form," "summary of contract provisions").

(3) A statement in at least 10-point bold face type to the effect that the disclosure form is a summary only and that the plan contract itself should be consulted to determine the governing contractual provisions.

(4) A statement to the effect that a specimen copy of the plan contract will be furnished on request.

(5) The caption "Principal Benefits and Coverages," followed by a description of such benefits and coverages.

(6) The caption "Principal Exclusions and Limitations on Benefits," followed by a description of the principal exclusions, exceptions, reductions and limitations that apply, and arranged in a uniform manner with the preceding section of the form.

(7) The caption "Prepayments Fees" followed by a statement of the methods by which such premium may be paid; the full premium charge of the plan; and a statement of the authority to change the fees during the term of the contract.

(8) The caption "Other Charges," followed by a description of each co-payment, co-insurance, or deductible requirement that may be incurred by the member or the member's family in obtaining coverage under the plan.

(9) The caption "Choice of Physicians and Providers," followed by a description of the nature, extent and circumstances under which choice is permitted. This section shall include, if applicable, a subcaption "Liability of Subscriber or Enrollee for Payment" followed by a description of the financial liability which is, or may be, incurred by the subscriber, enrollee or a third party by reason of the exercise of such choice.

(10) If applicable, the caption "Reimbursement Provisions," followed by a description of the circumstances under which reimbursements are made under the plan contract, the extent of reimbursement, and the method of claim for reimbursement.

(11) The caption "Facilities," followed by a statement of the principal facilities available under the plan contract, including their location and a description of the services, provided. The hours of availability of both emergency and nonemergency services should be indicated, either specifically or by general description. However, if the Director approves in advance, a plan may provide a telephone number from which information as to the identity and location of provider facilities defined in subsection (i)(2) of Section 1300.45 may be obtained, in lieu of listing such provider facilities.

(12) The caption "Renewal Provisions," followed by a statement of the terms under which the plan contract may be renewed by the group or the plan member, including any reservation by the plan of any right to change premiums or other plan contract provisions.

(13) In the case of group contracts, the caption "Individual Continuation of Benefits," followed by a statement of the terms and conditions under which subscribers and enrollees may remain in the plan, as provided pursuant to Subdivision (g) of Section 1373 of the Act.

(14) The caption "Termination of Benefits," followed by a statement of the terms and conditions for cancellation or termination of benefits, including a statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon a member who is hospitalized or undergoing treatment for an ongoing condition.

(c) In the event the receipt of benefits or reimbursements to subscribers or enrollees under the plan contract is subject to significant delays, based upon the current experience of the plan, the disclosure form may be required by the Director to disclose such facts.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1363, 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 subsections (b), (b)(11) and (c) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.63.1. Evidence of Coverage.

(a) Each plan shall furnish to each individual subscriber, and make available to group contract holders for dissemination to all persons eligible under the group contract, either an evidence of coverage or a copy of the plan contract, which shall conform to the requirements of this section. The Director may permit the evidence of coverage and the disclosure form prescribed by Section 1300.63 to be presented in a single document if the purposes of each are fulfilled.

(b) Except as may be otherwise permitted by the Director, the evidence of coverage shall conform to the requirements of subsection (a) of Section 1300.63 and the following requirements:

(1) It shall be clearly entitled "Evidence of Coverage."

(2) The portions of the text specifying (1) limitations, exclusions, exceptions and reductions; (2) rights of cancellation; (3) restrictions on renewal or reinstatement; (4) rights of the health plan to change benefits; (5) subsequent providers; and (6) liability of members in the event of nonpayment by the health plan, shall be in type not less than 2 points larger than the text relating to other provisions and in no event less than 12 point type.

(3) It shall be divided into sections, each of which shall have a title identifying the nature of the information contained therein.

(4) The evidence of coverage when taken as a whole, with consideration being given to format, typography and language, must constitute a fair disclosure of the provisions of the health plan.

(c) The evidence of coverage shall contain at a minimum the following information:

(1) The name of the health plan, the principal address from which it conducts its business and its telephone number.

(2) The definitions for the words contained therein that have meanings other than those attributed to them by the public in general usage.

(3) The manner in which the member can determine who is or may be entitled to benefits.

(4) The time and date or occurrence upon which coverage takes effect including a specification of any applicable waiting periods.

(5) The time and date or occurrence upon which coverage will terminate.

(6) The conditions upon which cancellation may be effected by the health plan or by the member, and a statement that a subscriber or enrollee who alleges that an enrollment or subscription has been cancelled or not renewed because of the enrollee's or subscriber's health status or requirements for health care services may request a review of cancellation by the Director.

(7) The conditions for and any restrictions upon the member's right to renewal or reinstatement.

(8) The amount of the periodic payment to be made by the member, the time by which the payment must be made, and the address at or to which the payment shall be made, except that a member under group coverage may be referred to the group contract holder for information regarding any sums to be withheld from the member's salary or to be paid by the member to the employer or group contract holder.

(9) A complete statement of all benefits and coverages and the related limitations, exclusions, exceptions, reductions, copayments, and deductibles.

(10) A statement of any restriction on assignment of sums payable to the member by the health plan.

(11) The exact procedure for obtaining benefits including the procedure for filing claims. The procedure for filing claims must state the time by which the claim must be filed, the form in which it is to be filed and the address at or to which it shall be delivered or mailed.

(12) Any procedures required to be followed by the member in the event any dispute arises under the contract, including any requirement for arbitration.

(13) The address and telephone number designated by the health plan to which complaints from members are to be directed, and a description of the plan's grievance procedure.

(14) A statement to the effect that, by statute, every contract between the health plan and a provider shall provide that in the event the health plan fails to pay the provider, the member shall not be liable to the provider for any sums owed by the health plan.

(15) A statement to the effect that in the event the health plan fails to pay a noncontracting provider, the member may be liable to the noncontracting provider for the cost of the services.

(16) An appropriate statement to fulfill the requirement of Section 1300.69(i)(1), unless the plan undertakes to mail such information annually.

(17) A statement which shall be set forth in boldface type not less than 2 points larger than the type required by subsection (b)(2): "This evidence of coverage constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage."

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1360 and 1363, Health and Safety Code.

HISTORY:

1. Amendment of subsection (c)(16) filed 6-2-78; effective thirtieth day thereafter (Register 78, No. 22).
2. Amendment of subsection (c) filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
3. Change without regulatory effect amending subsections (a), (b) and (c)(6) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.63.2. Combined Evidence of Coverage and Disclosure Form.

Notwithstanding Sections 1300.63 and 1300.63.1 of these rules, a plan may combine the evidence of coverage and disclosure form into a single document if such plan complies with each of the following requirements:

(a) Each plan shall furnish to each individual subscriber, and make available to group contract holders for dissemination to all persons eligible under the group contract, either a single document consisting of a combined evidence of coverage and disclosure form or a copy of the plan contract, which shall conform to the requirements of this section.

(b) Except as may be otherwise permitted by the Director, the combined evidence of coverage and disclosure form shall conform to the following requirements:

(1) It shall be clearly entitled "Combined Evidence of Coverage and Disclosure Form."

(2) The text shall be printed in at least ten point block type. Titles and captions shall be in at least twelve point to fifteen point boldface type.

(3) It shall be written in clear, concise, easily understood language.

(4) It should relate to one form of plan contract; however, combined evidence of coverage and disclosure forms offering alternative plans or options will be permitted if presented in a manner which clearly identifies the alternatives and their effect upon the contract.

(5) It shall be presented in an easily readable format.

(6) The combined evidence of coverage and disclosure form when taken as a whole, with consideration being given to format, typography and language, must constitute a fair disclosure of the provisions of the health plan.

(c) The combined evidence of coverage and disclosure form shall contain at a minimum the following information:

(1) The name of the health plan, the principal address from which it conducts its business and its telephone number.

(2) A statement that the specimen of the plan contract will be furnished on request.

(3) The definitions for the words contained therein that have meanings other than those attributed to them by the public in general usage.

(4) The manner in which the member can determine who is or may be entitled to benefits, except that a member under group coverage may be referred to the group contract holder for such information.

(5) The time and date or occurrence upon which coverage takes effect including a specification of any applicable waiting periods.

(6) The time and date or occurrence upon which coverage will terminate.

(7) The conditions upon which cancellation may be effected by the health plan or by the member, and a statement that a subscriber or enrollee who alleges that an enrollment or subscription has been cancelled or not renewed because of the enrollee's or subscriber's health status or requirements for health care services may request a review of cancellation by the Director.

(8) The conditions for and any restrictions upon the member's right to renewal or reinstatement.

(9) The caption "Prepayment Fees" followed by a statement of the methods by which such premium may be paid; the full premium charge of the plan; and a statement of the authority to change the fees during the term of the contract.

(10) The amount of the periodic payment to be made by the member, the time by which the payment must be made, and the address at or to which the payment shall be made, except that a member under group coverage may be referred to the group contract holder for information regarding any sums to be withheld from the member's salary or to be paid by the member to the employer or group contract holder.

(11) A complete statement of all benefits and coverages and the related limitations, exclusions, exceptions, reductions, copayments, and deductibles.

(12) The caption "Other Charges," followed by a description of each copayment, coinsurance, or deductible requirement that may be incurred by the member or the member's family in obtaining coverage under the plan.

(13) A statement of any restriction on assignment of sums payable to the member by the health plan.

(14) The exact procedure for obtaining benefits including the procedure for filing claims. The procedure for filing claims must state the time by which the claim must be filed, the form in which it is to be filed, and the address at or to which it shall be delivered or mailed.

(15) Any procedures required to be followed by the member in the event any dispute arises under the contract, including any requirement for arbitration.

(16) The address and telephone number designated by the health plan to which complaints from members are to be directed, and a description of the plan's grievance procedure.

(17) The caption "Choice of Physicians and Providers," followed by description of the nature, extent and circumstances under which choice is permitted. This section shall include, if applicable, a subcaption "Liability of Subscriber or Enrollee for Payment" followed by a description of the financial liability which is, or may be, incurred by the subscriber, enrollee or a third party by reason of the exercise of such choice.

(18) A statement to the effect that, by statute, every contract between the health plan and a provider shall provide that in the event the health plan fails to pay the provider, the member shall not be liable to the provider for any sums owed by the health plan.

(19) A statement to the effect that in the event the health plan fails to pay noncontracting providers, the member may be liable to the noncontracting provider for the cost of services.

(20) If applicable, the caption "Reimbursement Provisions," followed by a description of the circumstances under which reimbursements are made under the plan contract, the extent of reimbursement, and the method of claim for reimbursement.

(21) The caption "Renewal Provisions," followed by a statement of the terms under which the plan contract may be renewed by the group or the plan member, as appropriate, including any reservation by the plan of any right to change premiums or other plan contract provisions.

(22) The caption "Facilities," followed by a statement of the principal facilities available under the plan contract, including their location and description of the services provided. The hours of availability of both emergency and non-emergency services should be indicated, either specifically or by general description. However, if the Director approves in advance, a plan may provide a telephone number from which information as to the identity and location of the provider facilities defined in subsection (i)(2) of Section 1300.45 of these rules may be obtained, in lieu of listing such provider facilities.

(23) In the case of group contracts, the caption "Individual Continuation of Benefits," followed by a statement of the terms and conditions under which subscribers and enrollees may remain in the plan, as provided pursuant to subdivision (g) of Section 1373 of the Act.

(24) The caption "Termination of Benefits," followed by a statement of the terms and conditions for cancellation or termination of benefits, including a statement as to when benefits shall cease in the event of nonpayment of the prepaid or periodic charge and the effect of nonpayment upon a member who is hospitalized or undergoing treatment for an ongoing condition.

(25) Any appropriate statement to fulfill the requirement of Section 1300.69(i)(1) of these rules, unless the plan undertakes to mail such information annually.

(26) In the event that receipt of benefits or reimbursements to subscribers or enrollees under the plan contract is subject to significant delays, based upon the current experience of the plan, the combined evidence of coverage and disclosure form may be required by the Director to disclose such facts.

(27) A statement which shall be set forth in boldface type not less than two points larger than the type required by subsection (b)(2): "This combined evidence of coverage and disclosure form constitutes only a summary of the health plan. The health plan contract must be consulted to determine the exact terms and conditions of coverage."

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Sections 1345, 1360, 1363 and 1368, Health and Safety Code.

HISTORY:
1. New section filed 8-12-82; effective thirtieth day thereafter (Register 82, No. 33).
2. Change without regulatory effect amending subsections (b), (c)(7), (c)(22) and (c)(26) filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).

§ 1300.63.3. Experimental Disclosure.

Notwithstanding those provisions of Sections 1300.63, 1300.63.1, 1300.63.2, and 1300.67.4 which require the use of any particular type size, boldface type, caption, subcaption, heading, design, order, or format, the Director by order may approve, for experimental use, reasonable alternatives to such requirements for a disclosure form, evidence of coverage, combined evidence of coverage and disclosure form, or plan contract upon the written request of a plan, for such period and under such conditions as the Director may specify, subject to each of the following conditions:

(a) That the plan submits two draft copies of the document containing the proposed alternatives, one as proposed to be used and the other redlined to highlight the proposed changes, along with two copies of the related plan contract, at least 30 days prior to any use of the document, or such shorter period as the Director by order may allow.

(b) That the plan demonstrates to the satisfaction of the Director that the document containing the proposed alternatives furthers the purposes of the Act, otherwise complies with the Act and the rules thereunder, and will provide to actual or potential subscribers or enrollees (as the case may be) unobjectionable information at least as clear, concise, accurate, easily understood, and easily readable as could otherwise be achieved.

(c) That the plan submits a proof or final copy of the document at such time, not to exceed 30 days, prior to its initial use as may be specified by the Director.

NOTE: Authority cited: Section 1344, Health and Safety Code. Reference: Section 1363, Health and Safety Code.

HISTORY:
1. New section filed 1-12-83; effective thirtieth day thereafter (Register 83, No. 3).
2. Change without regulatory effect amending section filed 7-18-2000 pursuant to section 100, title 1, California Code of Regulations (Register 2000, No. 29).