§ 1345. Definitions

As used in this chapter:

(a) "Advertisement" means any written or printed communication or any communication by means of recorded telephone messages or by radio, television, or similar communications media, published in connection with the offer or sale of plan contracts.

(b) "Basic health care services" means all of the following:

(1) Physician services, including consultation and referral.

(2) Hospital inpatient services and ambulatory care services.

(3) Diagnostic laboratory and diagnostic and therapeutic radiologic services.

(4) Home health services.

(5) Preventive health services.

(6) Emergency health care services, including ambulance and ambulance transport services and out-of-area coverage. "Basic health care services" includes ambulance and ambulance transport services provided through the "911" emergency response system.

(7) Hospice care pursuant to Section 1368.2.

(c) "Enrollee" means a person who is enrolled in a plan and who is a recipient of services from the plan.

(d) "Evidence of coverage" means any certificate, agreement, contract, brochure, or letter of entitlement issued to a subscriber or enrollee setting forth the coverage to which the subscriber or enrollee is entitled.

(e) "Group contract" means a contract which by its terms limits the eligibility of subscribers and enrollees to a specified group.

(f) "Health care service plan" or "specialized health care service plan" means either of the following:

(1) Any person who undertakes to arrange for the provision of health care services to subscribers or enrollees, or to pay for or to reimburse any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(2) Any person, whether located within or outside of this state, who solicits or contracts with a subscriber or enrollee in this state to pay for or reimburse any part of the cost of, or who undertakes to arrange or arranges for, the provision of health care services that are to be provided

wholly or in part in a foreign country in return for a prepaid or periodic charge paid by or on behalf of the subscriber or enrollee.

(g) "License" means, and "licensed" refers to, a license as a plan pursuant to Section 1353.

(h) "Out-of-area coverage," for purposes of paragraph (6) of subdivision (b), means coverage while an enrollee is anywhere outside the service area of the plan, and shall also include coverage for urgently needed services to prevent serious deterioration of an enrollee's health resulting from unforeseen illness or injury for which treatment cannot be delayed until the enrollee returns to the plan's service area.

(i) "Provider" means any professional person, organization, health facility, or other person or institution licensed by the state to deliver or furnish health care services.

(j) "Person" means any person, individual, firm, association, organization, partnership, business trust, foundation, labor organization, corporation, limited liability company, public agency, or political subdivision of the state.

(k) "Service area" means a geographical area designated by the plan within which a plan shall provide health care services.

(*l*) "Solicitation" means any presentation or advertising conducted by, or on behalf of, a plan, where information regarding the plan, or services offered and charges therefor, is disseminated for the purpose of inducing persons to subscribe to, or enroll in, the plan.

(m) "Solicitor" means any person who engages in the acts defined in subdivision (*l*).

(n) "Solicitor firm" means any person, other than a plan, who through one or more solicitors engages in the acts defined in subdivision (*l*).

(o) "Specialized health care service plan contract" means a contract for health care services in a single specialized area of health care, including dental care, for subscribers or enrollees, or which pays for or which reimburses any part of the cost for those services, in return for a prepaid or periodic charge paid by or on behalf of the subscribers or enrollees.

(p) "Subscriber" means the person who is responsible for payment to a plan or whose employment or other status, except for family dependency, is the basis for eligibility for membership in the plan.

(q) Unless the context indicates otherwise, "plan" refers to health care service plans and specialized health care service plans.

(r) "Plan contract" means a contract between a plan and its subscribers or enrollees or a person contracting on their behalf pursuant to which health care services, including basic health care services, are furnished; and unless the context otherwise indicates it includes specialized health care service plan contracts; and unless the context otherwise indicates it includes group contracts.

(s) All references in this chapter to financial statements, assets, liabilities, and other accounting items mean those financial statements and accounting items prepared or determined in accordance with generally accepted accounting principles, and fairly presenting the matters which they purport to present, subject to any specific requirement imposed by this chapter or by the director.

HISTORY:
Added Stats 1990 ch 1043 § 4 (SB 785), operative April 1, 1993. Amended Stats 1994 ch 1010 § 154 (SB 2053); Stats 1995 ch 515 § 1 (SB 1151); Stats 1998 ch 979 § 1 (AB 984), ch 1025 § 1 (SB 658), ch 1026 § 2 (AB 1899); Stats 1999 ch 525 § 42 (AB 78), ch 528 § 1 (AB 892); Stats 2002 ch 760 § 1 (AB 3048).

§ 1345.5. "Minimum essential coverage"

(a) "Minimum essential coverage" means any of the following:

(1) Coverage under any of the following government-sponsored programs:

(A) The Medicare program under Part A or Part C of Title XVIII of the federal Social Security Act.

(B) Full scope coverage under the Medi-Cal program, including the Medi-Cal Access Program and Medi-Cal for Pregnant Women, and other full scope health coverage programs administered and determined to be minimum essential coverage by the State Department of Health Care Services.

(C) The Medicaid program under Title XIX of the federal Social Security Act.

(D) The CHIP program under Title XXI of the federal Social Security Act or under a qualified CHIP look-alike program, as defined in Section 2107(g) of the federal Social Security Act.

(E) Medical coverage under Chapter 55 of Title 10 of the United States Code, including coverage under the TRICARE program.

(F) A health care program under Chapter 17 or Chapter 18 of Title 38 of the United States Code.

(G) A health plan under Section 2504(e) of Title 22 of the United States Code, relating to Peace Corps volunteers.

(H) The Nonappropriated Fund health benefits program of the Department of Defense, established under Section 349 of the National Defense Authorization Act for Fiscal Year 1995.

(I) Refugee Medical Assistance, supported by the Administration for Children and Families, which is authorized under Section 412(e)(7)(A) of The Immigration and Nationality Act.

(J) A successor program to one of the above programs, as determined by the department or, pursuant to subparagraph (B), by the State Department of Health Care Services.

(2) The University of California Student Health Insurance Plan and the University of California Voluntary Dependent Plan.

(3) Coverage under an eligible employer-sponsored plan, including grandfathered plans and policies. "Eligible employer-sponsored plan" means a group health plan offered in connection with employment to an employee or related individuals, including a governmental plan within the meaning of Section 2791(d)(8) of the federal Public Health Service Act (42 U.S.C. Sec. 201 et seq.) or any other plan, group health care service plan contract, or group health insurance policy offered in the small or large group market within the state.

(4) Coverage under an individual health care service plan contract or individual health insurance policy, including grandfathered contracts and policies, or student health coverage that substantially meets all the requirements of Title I of the Affordable Care Act pertaining to nongrandfathered, individual health insurance coverage.

(5) Any other health benefits coverage similar in form and substance to the benefits described in this subdivision that is determined by the department to constitute minimum essential coverage pursuant to this section.

(b) "Minimum essential coverage" does not include health coverage as follows:

(1) Coverage of the following excepted benefits:

(A) Coverage only for accident or disability income insurance, or a combination of the two.

(B) Coverage issued as a supplement to liability insurance.

(C) Liability insurance, including general liability insurance and automobile liability insurance.

(D) Workers' compensation or similar insurance.

(E) Automobile medical payment insurance.

(F) Credit-only insurance.

(G) Coverage for onsite medical clinics.

(H) Other similar health coverage, under which benefits for medical care are secondary or incidental to other health benefits.

(2) Coverage of the following excepted benefits, if offered separately:

(A) Limited scope dental or vision benefits, or benefits limited to any other single specialized area of health care.

(B) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof.

(C) Other similar, limited benefits.

(3) Coverage of the following excepted benefits if offered as independent, noncoordinated benefits.

(A) Coverage only for a specified disease or illness.

(B) Hospital indemnity or other fixed indemnity insurance.

(4) Coverage of the following excepted benefits if offered as a separate contract for health care coverage:

(A) Medicare supplemental health insurance, as defined under Section 1395ss(g)(1) of Title 42 of the United States Code.

(B) Coverage supplemental to the coverage provided under Chapter 55 (commencing with Section 1071) of Title 10 of the United States Code.

(c) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department, or the State Department of Health Care Services, may implement, interpret, or make specific this section by means of guidance or instructions, without taking regulatory action.

HISTORY:

Added Stats 2019 ch 38 § 14 (SB 78), effective June 27, 2019.

ARTICLE 2

Administration

Section

1346. Powers of administration.
1346.1. Database of health care service plans.

Section
1346.2. Coordination with Insurance Commissioner to review specified Internet portal and enhancements; Development and maintenance of electronic clearinghouse.
1346.4. Legislative findings; Publication of code provisions.
1346.5. Entity purporting to be exempt health care service plan.
1347. [Section repealed 2006.]
1347.1. [Section repealed 2006.]
1347.15. Establishment of Financial Solvency Standards Board; Members; Purpose, Meetings.
1347.5. Implementation of Medi-Cal program's premium and cost-sharing payments by health care service plan.
1347.8. Annual report on funds maintained in segregated account pursuant to federal Patient Protection and Affordable Care Act.
1348. Antifraud plan.
1348.5. Compliance with other law.
1348.6. Proscription on payment to health care practitioner to deny, limit, or delay services.
1348.8. Requirements for telephone medical advice services; Forwarding of data to Department of Consumer Affairs.
1348.9. Adoption of regulations establishing Consumer Participation Program; Award of advocacy and witness fees.
1348.95. Annual report to department.
1348.96. Submission of data for risk adjustment program.

HISTORY: Added Stats 1975 ch 941 § 2, operative July 1, 1976.