

AMENDED IN SENATE MAY 8, 2013
AMENDED IN SENATE APRIL 24, 2013

SENATE BILL

No. 780

Introduced by Senator Jackson

February 22, 2013

An act to amend Section 1373.65 of the Health and Safety Code, and to amend Sections 10123.12, 10601, and 10604 of, and to add Section 10133.57 to, the Insurance Code, relating to ~~insurance~~: *health care coverage*.

LEGISLATIVE COUNSEL'S DIGEST

SB 780, as amended, Jackson. Health care coverage.

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care and makes a willful violation of the act a crime.

Existing law requires a health care service plan to submit a filing to the department at least 75 days prior to the termination date of its contract with a provider group or a general acute care hospital that includes the written notice the plan proposes to send to its affected enrollees. The filing is required to be reviewed and approved by the department prior to the notice being sent the enrollees. Existing law also requires the plan to provide written notice to affected enrollees, as provided, prior to the termination date of a contract between the plan and a provider group or a general acute care hospital. A plan operating as a preferred provider organization is only required to send the written notice to all enrollees who reside within a 15-mile radius of a terminated hospital if it is a general acute care hospital.

This bill would delete the requirements with regard to preferred provider organizations. *The bill would change the timing of the 75-day filing to 45 days prior to the termination date for a contract between a health care service plan that is not a health maintenance organization and a provider group or general acute care hospital, and would not prohibit the plan from sending the notice to the enrollees prior to the filing being reviewed and approved by the department.* The bill would distinguish between enrollees of an assigned group provider and enrollees of an unassigned group provider for purposes of whether ~~the 75-day~~ the filing is required to be submitted to the department. The bill would also require that the plan send a department approved written notice to the enrollees, whether or not a filing was required, when a provider group contract or a general acute care hospital contract is terminated. The bill would distinguish between the enrollees of an assigned or an unassigned provider group or general acute care hospital with regard to the timing of the consumer notice and method of delivery, and would impose specified continued access to services ~~and requirements~~, billing requirements, *and requirements to obtain information* on plans and providers for the enrollees of an unassigned provider group or an unassigned general acute care hospital. Because a willful violation of these requirements with respect to health care service plans would be a crime, the bill would impose a state-mandated local program.

Existing law provides for the regulation of health insurers by the Department of Insurance. Under existing law, a health insurer may contract with providers for alternative rates of payment. Existing law requires those insurers to file a policy with the department describing how the insurer facilitates the continuity of care for new insureds under group policies receiving services for an acute condition from a noncontracting provider. Existing law also requires those health insurers to, at the request of an insured, arrange for the completion of covered services by a terminated provider if the insured is undergoing treatment for certain conditions, as specified.

This bill would require, among other things, a health insurer to submit a filing to the department, at least ~~75~~ 45 days prior to the termination date of its contract with a provider group or a general acute care hospital to provide services at alternative rates of payment, that includes the written notice the insurer proposes to send to its insureds. The bill would require the filing to be reviewed and approved by the department prior to the notice being sent to the insureds. The bill would set a threshold

for the number of insureds receiving health care services from a group provider within the preceding 12 months for purposes of whether the filing is required to be submitted to the department. The bill would also require that the health insurer send a department approved written notice to specified insureds, whether or not a filing was required, when a provider group contract or a general acute care hospital contract is terminated, and would impose specified continued access to services ~~and~~ *requirements*, billing requirements, *and requirements to obtain information* on insurers and providers for insureds receiving health care services from a terminated provider group or general acute care hospital.

Existing law requires disability insurance policies to include a disclosure form that contains specified information, including the principal benefits and coverage of the policy, the exceptions, reductions, and limitations that apply to the policy, and a statement, with respect to health insurance policies, describing how participation in the policy may affect the choice of physician, hospital, or health care providers, and describing the extent of financial liability that may be incurred if care is furnished by a nonparticipating provider.

With respect to health insurance policies, this bill would require the disclosure form to include additional information, including conditions and procedures for cancellation, rescission, or nonrenewal, a description of the limitations on the insured's choice of provider, and, with respect to insurers that contract for alternate rates of payment, a statement describing the basic method of reimbursement made to its participating providers, as specified. The bill would also require the first page of the disclosure form for health insurance policies to include other specified information. The bill would require a health insurer, medical group, or participating provider that uses or receives financial bonuses or other incentives to provide a written summary of specified information to any requesting person.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes.
State-mandated local program: yes.

The people of the State of California do enact as follows:

1 SECTION 1. Section 1373.65 of the Health and Safety Code
2 is amended to read:

3 1373.65. (a) For the purposes of this section, the following
4 terms have the following meanings:

5 (1) “Assigned general acute care hospital” means a general acute
6 care hospital to which the health *care service* plan, either directly
7 or through its contracts with its delegated entities, directs enrollees
8 to receive nonemergency services.

9 (2) “Assigned provider group” means a provider group to which
10 a health *care service* plan directs its enrollees to receive specialty
11 physician services or a provider group that includes primary care
12 physicians to which a health *care service* plan assigns its members.

13 (3) “Provider group” means a medical group, independent
14 practice association, or any other similar organization.

15 (4) “Unassigned general acute care hospital” is a general acute
16 care hospital that is not an assigned general acute care hospital.

17 (5) “Unassigned provider group” means a provider group that
18 is not an assigned provider group.

19 (b) (1) ~~At~~ *Except as provided in paragraph (2), at least 75 days*
20 *prior to the termination date of its contract with a provider group*
21 *or a general acute care hospital, the health care service plan shall*
22 *submit a filing to the department that includes the written notice*
23 *the plan proposes to send to enrollees. The plan shall not send this*
24 *notice to enrollees until the department has reviewed and approved*
25 *the filing. If the department does not respond within seven days*
26 *of the date of its receipt of the filing, the filing shall be deemed*
27 *approved.*

28 (2) *At least 45 days prior to the termination date of a contract*
29 *between a health care service plan that is not a health maintenance*
30 *organization and a provider group or a general acute care*
31 *hospital, the health care service plan shall submit a filing to the*
32 *department that includes the written notice the plan proposes to*
33 *send to enrollees.*

34 ~~(2)~~

35 (3) For the purposes of a termination with an assigned provider
36 group *or assigned general acute care hospital*, the health care
37 service plan shall submit a filing to the department, as required by
38 paragraph (1), if 2,000 or more enrollees will be transferred or

1 redirected by the plan from the assigned provider group as a result
2 of the termination of the provider contract.

3 ~~(3)~~

4 (4) For purposes of a termination with an unassigned provider
5 group, the health care service plan shall submit a filing to the
6 department, as required by paragraph (1) *or* (2), if 1,700 or more
7 enrollees were treated by the unassigned provider group within
8 the 12 months preceding the filing date specified in paragraph (1)
9 *or* (2).

10 ~~(4)~~

11 (5) The director may adopt by regulation a different filing
12 threshold from the threshold stated in ~~paragraph (2)~~ *paragraphs*
13 *(3) and (4)*, and in consultation with the Department of Insurance,
14 may adopt by regulation a different filing threshold from the
15 threshold stated in ~~paragraph (3)~~ *paragraphs (3) and (4)*.

16 (c) (1) In the event of a contract termination between a health
17 care service plan and an assigned provider group or an assigned
18 general acute care hospital, the plan shall do all of the following:

19 (A) Send the written notice described in subdivision (b) by
20 United States mail at least 60 days prior to the termination date to
21 enrollees who are assigned to the terminated provider group or
22 general acute care hospital.

23 (B) A plan that is unable to comply with the timeframe in
24 subparagraph (A) because of exigent circumstances shall apply to
25 the department for a waiver. The plan ~~is~~ *shall be* excused from
26 complying with the 60-day notice requirement only if its waiver
27 application is granted by the department or the department does
28 not respond within seven days of the date of its receipt of the
29 waiver application.

30 (2) In the event of a contract termination between a health care
31 service plan and an unassigned provider group or an unassigned
32 general acute care hospital, the plan shall do all of the following:

33 (A) Send the written notice described in subdivision (b), within
34 ~~one business day~~ *five business days* of the contract termination
35 with an unassigned provider group, to all of the following persons:

36 (i) Any unassigned enrollee who has received health care
37 services from the terminated ~~unassigned~~ provider group within the
38 12 months preceding the date of termination.

39 (ii) Any unassigned enrollee who has any health care services
40 ~~scheduled with the terminated unassigned provider group~~

1 *authorized, but not yet scheduled as of the date of termination, or*
2 *scheduled for after the date of termination with the terminated*
3 *provider group.*

4 (B) Send the written notice described in subdivision (b), within
5 ~~one business day~~ *five business days* of the contract termination
6 with an unassigned general acute care hospital, to all of the
7 following persons:

8 (i) Any enrollee who has received health care services from the
9 terminated ~~unassigned~~ general acute care hospital within the 12
10 months preceding the date of termination.

11 (ii) Any enrollee who is assigned to a provider group with any
12 physicians who have exclusive admitting privileges to the
13 terminated ~~unassigned~~ general acute care hospital.

14 (iii) Any enrollee who has ~~authorized~~ health care services
15 ~~scheduled at a terminating unassigned general acute care hospital~~
16 *authorized, but not yet scheduled as of the date of termination, or*
17 *scheduled for after the date of termination at the terminated general*
18 *acute care hospital.*

19 (C) Allow enrollees to continue to access services that were
20 authorized or scheduled at the terminated unassigned provider
21 group or unassigned general acute care hospital prior to the date
22 of *either the notice required by subdivisions (c) and (d), or the*
23 *termination, whichever is later, regardless of whether the enrollee*
24 *has requested completion of covered services.* Those services shall
25 be provided *from the date of the contract termination* until
26 completion of the authorized or scheduled services for at least 60
27 days from the date of *either the notice* ~~unless a longer period of~~
28 ~~time is required pursuant to Section 1373.96.~~ *or the termination,*
29 *whichever is later.* The amount of, and the requirement for payment
30 of, copayments, deductibles, coinsurance, and other cost-sharing
31 components by an enrollee during the period of completion of
32 authorized or scheduled services with a terminated ~~unassigned~~
33 provider group or ~~unassigned~~ general acute care hospital pursuant
34 to this subparagraph shall be the same that would be paid by the
35 enrollee when receiving care from a provider currently contracting
36 with or employed by the plan.

37 (D) Provide reimbursement for services provided under
38 subparagraph (C) either at a rate agreed upon by the health care
39 service plan and the terminated provider group or general acute
40 care hospital or the rate for those services as provided in the

1 terminating contract. In no event shall the provider bill the patient
2 for the cost of services beyond the copayment, deductible, or other
3 cost-sharing components of what the enrollee would have been
4 responsible for if the provider group or general acute care hospital
5 was currently contracted with the health care service plan.

6 (E) Obtain information from the terminated provider group or
7 general acute care hospital regarding enrollees who have health
8 care services scheduled for after the date of termination with the
9 terminated provider group or general acute care hospital,
10 including the names of those enrollees and the dates on which
11 their services were scheduled. Unless otherwise prohibited by law,
12 a terminated provider group or general acute care hospital shall
13 comply with a health care service plan's request for that
14 information.

15 (d) Even if a filing is not required to be submitted by subdivision
16 (b), a health care service plan shall send enrollee notices as required
17 by subdivision (c). A health care service plan may only send
18 enrollee notices for which a template has been filed and approved
19 by the department pursuant to Section 1373.95.

20 (e) If an individual provider terminates his or her contract or
21 employment with a provider group that contracts with a health
22 care service plan, the plan may require that the provider group
23 send the notices required by subdivisions (c) and (d).

24 (f) If, after sending the notices required by subdivisions (c) and
25 (d), a health care service plan reaches an agreement with any
26 terminated provider group or general acute care hospital to renew
27 or enter into a new contract or to not terminate their contract, the
28 plan shall send a subsequent written notice to all enrollees that
29 were sent the notices required by subdivisions (c) and (d) informing
30 them of the status. The plan shall offer each affected enrollee the
31 option to return to that provider group or general acute care
32 hospital. If an assigned enrollee does not exercise this option, the
33 plan shall reassign the enrollee to another provider group or general
34 acute care hospital.

35 (g) A health care service plan and a provider group or general
36 acute care hospital shall include in all written, printed, or electronic
37 communications sent to an enrollee that concern the contract
38 termination or block transfer, the following statement in not less
39 than ~~8-point~~ 12-point type:

40

1 “If you have been receiving care from a health care provider,
 2 you may have a right to keep your provider for a designated time
 3 period. Please contact your HMO’s customer service department,
 4 and if you have further questions, you are encouraged to contact
 5 the Department of Managed Health Care, which protects HMO
 6 consumers, by telephone at its toll-free number, 1-888-HMO-2219,
 7 or at a TDD number for the hearing impaired at 1-877-688-9891,
 8 or online at www.hmohelp.ca.gov.”
 9

10 *(h) Nothing in this section shall be construed to limit the rights*
 11 *or protections of enrollees under Section 1373.96.*

12 SEC. 2. Section 10123.12 of the Insurance Code is amended
 13 to read:

14 10123.12. (a) Every health insurer, including those insurers
 15 that contract for alternative rates of payment pursuant to Section
 16 10133, and every self-insured employee welfare benefit plan that
 17 will affect the choice of physician, hospital, or other health care
 18 providers, shall include within its disclosure form and within its
 19 evidence or certificate of coverage a statement clearly describing
 20 how participation in the policy or plan may affect the choice of
 21 physician, hospital, or other health care providers, and describing
 22 the nature and extent of the financial liability that is, or that may
 23 be, incurred by the insured, enrollee, or covered dependents if care
 24 is furnished by a provider that does not have a contract with the
 25 insurer or plan to provide service at alternative rates of payment
 26 pursuant to Section 10133. The form shall clearly inform
 27 prospective insureds or plan enrollees that participation in the
 28 policy or plan will affect the person’s choice in this regard by
 29 placing the following statement in a conspicuous place on all
 30 material required to be given to prospective insureds or plan
 31 enrollees including promotional and descriptive material, disclosure
 32 forms, and certificates and evidences of coverage:
 33

34 PLEASE READ THE FOLLOWING INFORMATION SO
 35 YOU WILL KNOW FROM WHOM OR WHAT GROUP OF
 36 PROVIDERS HEALTH CARE MAY BE OBTAINED
 37

38 It is not the intent of this section to require that the names of
 39 individual health care providers be enumerated to prospective
 40 insureds or enrollees.

1 If a health insurer providing coverage for hospital, medical, or
2 surgical expenses provides a list of facilities to patients or
3 contracting providers, the insurer shall include within the listing
4 a notification that insureds or enrollees may contact the insurer in
5 order to obtain a list of the facilities with which the health insurer
6 is contracting for subacute care and/or transitional inpatient care.

7 (b) Every health insurer that contracts for alternative rates of
8 payment pursuant to Section 10133 shall include within its
9 disclosure form a statement clearly describing the basic method
10 of reimbursement, including the scope and general methods of
11 payment, made to its contracting providers of health care services,
12 and whether financial bonuses or any other incentives are used.
13 The disclosure form shall indicate that, if an insured wishes to
14 know more about these issues, the insured may request additional
15 information from the insurer, the insured's provider, or the
16 provider's medical group regarding the information required
17 pursuant to subdivision (c).

18 (c) If a health insurer, medical group, or participating health
19 care provider uses or receives financial bonuses or any other
20 incentives, the insurer, medical group, or health care provider shall
21 provide a written summary to any person who requests it that
22 includes both of the following:

23 (1) A general description of the bonus and any other incentive
24 arrangements used in its compensation agreements. Nothing in
25 this paragraph shall be construed to require disclosure of trade
26 secrets or commercial or financial information that is privileged
27 or confidential, such as payment rates, as determined by the
28 commissioner, pursuant to state law.

29 (2) A description regarding whether, and in what manner, the
30 bonuses and any other incentives are related to a provider's use of
31 referral services.

32 (d) The statements and written information provided pursuant
33 to subdivisions (b) and (c) shall be communicated in clear and
34 simple language that enables consumers to evaluate and compare
35 health insurance policies.

36 SEC. 3. Section 10133.57 is added to the Insurance Code, to
37 read:

38 10133.57. (a) For purposes of this section, "provider group"
39 means a medical group, independent practice association, or any
40 other similar organization.

1 (b) (1) At least ~~75~~ 45 days prior to the termination date of its
 2 contract with a provider group or a general acute care hospital to
 3 provide services at alternative rates of payment pursuant to Section
 4 10133, the health insurer shall submit a filing to the department
 5 that includes the written notice the insurer proposes to send to the
 6 insureds. The insurer shall not send this notice to the insureds until
 7 the department has reviewed and approved the filing. If the
 8 department does not respond to the ~~insured~~ insurer within seven
 9 days of the date of its receipt of the filing, the filing shall be
 10 deemed approved.

11 (2) For purposes of a termination with a provider group, the
 12 health insurer shall submit a filing to the department, as required
 13 by paragraph (1), if 1,700 or more insureds were treated by the
 14 provider group within the 12 months preceding the filing date
 15 specified in paragraph (1).

16 (3) The department, in consultation with the Department of
 17 Managed Health Care, may adopt by regulation a different filing
 18 threshold from the threshold stated in paragraph (2).

19 (c) In the event of a contract termination between a health
 20 insurer and a provider group or general acute care hospital, the
 21 insurer shall do all of the following:

22 (1) Send the written notice described in subdivision (b), within
 23 ~~one business day~~ five business days of the contract termination
 24 with a provider group, to all of the following persons:

25 (A) Any insured who has received health care services from the
 26 terminated provider group within the 12 months preceding the date
 27 of termination.

28 (B) Any insured who has any health care services *authorized,*
 29 *but not yet scheduled as of the date of termination, or* scheduled
 30 ~~with the terminated provider group~~ for after the date of termination
 31 *with the terminated provider group.*

32 (2) Send the written notice described in subdivision (b), within
 33 ~~one business day~~ five business days of the contract termination
 34 with a general acute care hospital, to all of the following persons:

35 (A) Any insured who has received health care services from the
 36 terminated general acute care hospital within the 12 months
 37 preceding the date of termination.

38 (B) Any insured who has ~~authorized~~ health care services
 39 *authorized, but not yet scheduled as of the date of termination, or*
 40 ~~scheduled at a terminating general acute care hospital~~ for after

1 the date of termination *at the terminated general acute care*
2 *hospital.*

3 (3) Allow insureds to continue to access services that were
4 authorized or scheduled at the terminated provider group or general
5 acute care hospital prior to the date of *either the notice required*
6 *by subdivisions (c) and (d), or the termination, whichever is later,*
7 *regardless of whether the insured has requested completion of*
8 *covered services.* Those services shall be provided *from the date*
9 *of the contract termination* until completion of the authorized or
10 scheduled services for at least 60 days from the date of *either the*
11 *notice unless a longer period of time is required pursuant to Section*
12 ~~10133.56~~ *or the termination, whichever is later.* The amount of,
13 and the requirement for payment of, copayments, deductibles,
14 coinsurance, and other cost-sharing components by an insured
15 during the period of completion of authorized or scheduled services
16 with a terminated provider group or general acute care hospital
17 pursuant to this paragraph shall be the same that would be paid by
18 the insured when receiving care from a provider currently
19 contracting with the insurer.

20 (4) Provide reimbursement for services provided under
21 paragraph (3) either at a rate agreed upon by the insurer and the
22 terminated provider group or general acute care hospital or the
23 rate for those services as provided in the terminating contract. In
24 no event shall the provider bill the patient for the cost of services
25 beyond the copayment, deductible, or other cost-sharing
26 components of what the insured would have been responsible for
27 if the provider group or general acute care hospital was currently
28 contracted with the insurer.

29 (5) *Obtain information from the terminated provider group or*
30 *general acute care hospital regarding insureds who have health*
31 *care services scheduled for after the date of termination with the*
32 *terminated provider group or general acute care hospital,*
33 *including the names of those insureds and the dates on which their*
34 *services were scheduled. Unless otherwise prohibited by law, a*
35 *terminated provider group or general acute care hospital shall*
36 *comply with a health insurer's request for that information.*

37 (d) Even if a filing is not required to be submitted by subdivision
38 (b), a health insurer shall send insured notices as required by
39 subdivision (c). A health insurer may only send insured notices

1 that have been filed and approved by the department pursuant to
2 this section.

3 (e) If an individual provider terminates his or her contract or
4 employment with a provider group that contracts with a health
5 insurer, the insurer may require that the provider group send the
6 notices required by subdivisions (c) and (d).

7 (f) If, after sending the notices required by subdivisions (c) and
8 (d), a health insurer reaches an agreement with a terminated
9 provider group or general acute care hospital to renew or enter
10 into a new contract or to not terminate its contract, the insurer shall
11 send a subsequent written notice to all insureds that were sent the
12 notices required by subdivisions (c) and (d) informing those
13 insureds that the provider group or hospital remains in their
14 provider network.

15 (g) A health insurer or a provider group shall include in all
16 written, printed, or electronic communications sent to an insured
17 that concern the contract termination, the following statement in
18 not less than ~~8-point~~ 12-point type:

19
20 “If you have been receiving care from a health care provider,
21 you may have a right to keep your provider for a designated time
22 period. Please contact your insurer’s customer service department,
23 and if you have further questions, you are encouraged to contact
24 the Department of Insurance, which protects insurance consumers,
25 by telephone at its toll-free number, 800-927-HELP (4357), or at
26 a TDD number for the hearing impaired at 800-482-4833, or online
27 at www.insurance.ca.gov.”

28
29 (h) The commissioner may adopt regulations in accordance with
30 the Administrative Procedure Act (Chapter 3.5 (commencing with
31 Section 11340) of Part 1 of Division 3 of Title 2 of the Government
32 Code) that are necessary to implement the provisions of this
33 section.

34 (i) *Nothing in this section shall be construed to limit the rights*
35 *or protections of insureds under Section 10133.56.*

36 SEC. 4. Section 10601 of the Insurance Code is amended to
37 read:

38 10601. As used in this chapter:

39 (a) “Benefits and coverage” means the accident, sickness, or
40 disability indemnity available under a policy of disability insurance.

1 (b) “Exception” means any provision in a policy whereby
2 coverage for a specified hazard or condition is entirely eliminated.

3 (c) “Reduction” means any provision in a policy that reduces
4 the amount of a policy benefit to some amount or period less than
5 would be otherwise payable for medically authorized expenses or
6 services had the reduction not been used.

7 (d) “Limitation” means any provision other than an exception
8 or a reduction that restricts coverage under the policy.

9 (e) “Presenting for examination or sale” means either (1)
10 publication and dissemination of any brochure, mailer,
11 advertisement, or form that constitutes a presentation of the
12 provisions of the policy and that provides a policy enrollment or
13 application form, or (2) consultations or discussions between
14 prospective beneficiaries or their contract agents and employees
15 or agents of disability insurers, when those consultations or
16 discussions include presentation of formal, organized information
17 about the policy that is intended to influence or inform the
18 prospective insured or beneficiary, such as brochures, summaries,
19 charts, slides, or other modes of information in lieu of or in addition
20 to the policy itself.

21 (f) “Disability insurance” means every policy of disability
22 insurance and self-insured employee welfare benefit plan issued,
23 delivered, or entered into pursuant to or described in Chapter 1
24 (commencing with Section 10110) or Chapter 4 (commencing with
25 Section 10270) of this part.

26 (g) “Insurer” means every insurer transacting disability insurance
27 and every self-insured employee welfare plan specified in
28 subdivision (f).

29 (h) “Disclosure form” means the standard supplemental
30 disclosure form required pursuant to Section 10603.

31 (i) “Small group health insurance policy” means a group health
32 insurance policy issued to a small employer, as defined in Section
33 10700, 10753, or 10755.

34 SEC. 5. Section 10604 of the Insurance Code is amended to
35 read:

36 10604. The disclosure form shall include at least the following
37 information, in concise and specific terms, relative to the disability
38 insurance policy, together with additional information as the
39 commissioner may require in connection with the policy:

- 1 (a) The applicable category or categories of coverage provided
2 by the policy, from among the following:
- 3 (1) Basic hospital expense coverage.
 - 4 (2) Basic medical-surgical expense coverage.
 - 5 (3) Hospital confinement indemnity coverage.
 - 6 (4) Major medical expense coverage.
 - 7 (5) Disability income protection coverage.
 - 8 (6) Accident only coverage.
 - 9 (7) Specified disease or specified accident coverage.
 - 10 (8) Other categories as the commissioner may prescribe.
- 11 (b) The principal benefits and coverage of the disability
12 insurance policy, including coverage for acute care and subacute
13 care if the policy is a health insurance policy, as defined in Section
14 106.
- 15 (c) The exceptions, reductions, and limitations that apply to the
16 policy.
- 17 (d) A summary, including a citation of the relevant contractual
18 provisions, of the process used to authorize, modify, delay, or deny
19 payments for services under the coverage provided by the policy
20 including coverage for subacute care, transitional inpatient care,
21 or care provided in skilled nursing facilities. This subdivision shall
22 only apply to policies of health insurance as defined in Section
23 106.
- 24 (e) The full premium cost of the policy.
- 25 (f) Any copayment, coinsurance, or deductible requirements
26 that may be incurred by the insured or his or her family in obtaining
27 coverage under the policy.
- 28 (g) The terms under which the policy may be renewed by the
29 insured, including any reservation by the insurer of any right to
30 change premiums.
- 31 (h) A statement that the disclosure form is a summary only, and
32 that the policy itself should be consulted to determine governing
33 contractual provisions.
- 34 (i) For a health insurance policy, as defined in Section 106, all
35 of the following:
- 36 (1) A notice on the first page of the disclosure form that
37 conforms with all of the following conditions:
 - 38 (A) (i) States that the form discloses the terms and conditions
39 of coverage.

1 (ii) States, with respect to individual health insurance policies,
2 small group health insurance policies, and any group health
3 insurance policies, that the applicant has a right to view the
4 disclosure form and policy prior to beginning coverage under the
5 policy, and, if the policy does not accompany the disclosure form,
6 the notice shall specify where the policy can be obtained prior to
7 beginning coverage.

8 (B) Includes a statement that the disclosure and the policy should
9 be read completely and carefully and that individuals with special
10 health care needs should read carefully those sections that apply
11 to them.

12 (C) Includes the insurer's telephone number or numbers that
13 may be used by an applicant to receive additional information
14 about the benefits of the policy, or states where those telephone
15 number or numbers are located in the disclosure form.

16 (D) For individual health insurance policies and small group
17 health insurance policies, states where a health policy benefits and
18 coverage matrix is located.

19 (E) Is printed in type no smaller than that used for the remainder
20 of the disclosure form and is displayed prominently on the page.

21 (2) A statement as to when benefits shall cease in the event of
22 nonpayment of premium and the effect of nonpayment upon an
23 insured who is hospitalized or undergoing treatment for an ongoing
24 condition.

25 (3) To the extent that the policy or insurer permits a free choice
26 of provider to its insureds, the statement shall disclose, consistent
27 with Section 10123.12, the nature and extent of choice permitted
28 and the financial liability that is, or may be, incurred by the insured,
29 covered dependents, or a third party by reason of the exercise of
30 that choice.

31 (4) For group health insurance policies, including small group
32 health insurance policies, a summary of the terms and conditions
33 under which insureds may remain in the policy in the event the
34 group ceases to exist, the group policy is terminated, an individual
35 insured leaves the group, or the insureds' eligibility status changes.

36 (5) If the policy utilizes arbitration to settle disputes, a statement
37 of that fact. If the policy requires binding arbitration, a disclosure
38 pursuant to Section 10123.19.

39 (6) A description of any limitations on the insured's choice of
40 primary care physician, specialty care physician, or nonphysician

1 health care practitioner, based on service area and limitations on
2 the insured's choice of acute care hospital care, subacute or
3 transitional inpatient care, or skilled nursing facility.

4 (7) Conditions and procedures for cancellation, rescission, or
5 nonrenewal.

6 (8) A description as to how an insured may request continuity
7 of care as required by Sections 10133.55 and 10133.56, and request
8 a second opinion pursuant to Section 10123.68.

9 (9) Information concerning the right of an insured to request an
10 independent medical review in accordance with Article 3.5
11 (commencing with Section 10169) of Chapter 1.

12 (10) A notice as required by Section 791.04.

13 SEC. 6. No reimbursement is required by this act pursuant to
14 Section 6 of Article XIII B of the California Constitution because
15 the only costs that may be incurred by a local agency or school
16 district will be incurred because this act creates a new crime or
17 infraction, eliminates a crime or infraction, or changes the penalty
18 for a crime or infraction, within the meaning of Section 17556 of
19 the Government Code, or changes the definition of a crime within
20 the meaning of Section 6 of Article XIII B of the California
21 Constitution.