AMENDED IN ASSEMBLY JUNE 30, 2014

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 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 *to* 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~~ *30* 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 filing is required to be submitted to the department. The bill would also require that the plan send a ~~department approved~~ *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~~ *delivery. With respect to the termination of a contract with an unassigned provider group or general acute care hospital, the bill* would impose specified continued access to services 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.~~ *from the terminated provider group or general acute care hospital regarding enrollees who have services scheduled with the terminated provider group or general acute care hospital for after the termination date using a process agreed upon in the terminating contract. The bill would authorize the department to develop a standard format for the required notices.* 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 ~~45~~ *30* 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~~ *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 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.~~ *from the terminated provider group or general acute care hospital regarding insureds who have services scheduled with the terminated provider group or general acute care hospital for after the termination date using a process agreed upon in the terminating contract. The bill would authorize the department to develop a standard format for the required notices.*

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:

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

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

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

(2) "Assigned provider group" means a provider group to which a health care service plan directs its enrollees to receive specialty physician services or a provider group that includes primary care physicians to which a health care service plan assigns its members.

(3) "Provider group" means a medical group, independent practice association, or any other similar organization.

(4) "Unassigned general acute care hospital" is a general acute care hospital that is not an assigned general acute care hospital.

(5) "Unassigned provider group" means a provider group that is not an assigned provider group.

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

(2) At least ~~45~~ *30* days prior to the termination date of a contract between a health care service plan that is not a health maintenance organization and a provider group or a general acute care hospital, the health care service plan shall submit a filing to the department that includes the written notice the plan proposes to send to enrollees. *The plan shall not send this notice to enrollees until the department has reviewed and approved the filing. If the department does not respond to the plan within seven days of the date of its receipt of the filing, the filing shall be deemed approved.*

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

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

(5) The director may adopt by regulation a different filing threshold from the threshold stated in paragraphs (3) and (4), and in consultation with the Department of Insurance, may adopt by regulation a different filing threshold from the threshold stated in paragraphs (3) and (4).

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

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

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

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

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

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

(ii) Any unassigned enrollee who has any health care services authorized, but not yet scheduled as of the date of termination, or scheduled for after the date of termination with the terminated provider group.

(B) Send the written notice described in subdivision (b), within five business days of the contract termination with an unassigned general acute care hospital, to all of the following persons:

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

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

(iii) Any enrollee who has health care services authorized, but not yet scheduled as of the date of termination, or scheduled for after the date of termination at the terminated general acute care hospital.

(C) Allow enrollees to continue to access services that were authorized or scheduled at the terminated unassigned provider group or unassigned general acute care hospital prior to the date of either the notice required by subdivisions (c) and (d), or the termination, whichever is later, regardless of whether the enrollee has requested completion of covered services. Those services shall be provided from the date of the contract termination until completion of the authorized or scheduled services for at least 60 days from the date of either the notice or the termination, whichever is later. The amount of, and the requirement for payment of, copayments, deductibles, coinsurance, and other cost-sharing components by an enrollee during the period of completion of authorized or scheduled services with a terminated provider group or general acute care hospital pursuant to this subparagraph shall

be the same that would be paid by the enrollee when receiving care from a provider currently contracting with or employed by the plan.

(D) Provide reimbursement for services provided under subparagraph (C) ~~either~~ at a rate agreed upon by the health care service plan and the terminated provider group or general acute care ~~hospital or~~ *hospital. If there is not an agreement, reimbursement shall be at* the rate for those services as provided in the terminating contract. In no event shall the provider bill the patient for the cost of services beyond the copayment, deductible, or other cost-sharing components of what the enrollee would have been responsible for if the provider group or general acute care hospital was currently contracted with the health care service plan.

(E) Obtain information from the terminated provider group or general acute care hospital regarding enrollees who have health care services scheduled for after the date of termination with the terminated provider group or general acute care hospital, including the names of those enrollees and the dates on which their services were ~~scheduled.~~ *scheduled by using the process agreed to in the terminating contract.* Unless otherwise prohibited by law, a terminated provider group or general acute care hospital ~~shall comply with a health care service plan's request for that information.~~ *and the health care service plan shall comply with the process in the terminating contract.*

(d) Even if a filing is not required to be submitted by subdivision (b), a health care service plan shall send enrollee notices as required by subdivision (c). A health care service plan may only send enrollee notices for which a template has been filed and approved by the department pursuant to Section 1373.95. *The department may develop a standard format for notices to be sent as required by this section.*

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

(f) If, after sending the notices required by subdivisions (c) and (d), a health care service plan reaches an agreement with any terminated provider group or general acute care hospital to renew or enter into a new contract or to not terminate their contract, the plan shall send a subsequent written notice to all enrollees that

were sent the notices required by subdivisions (c) and (d) informing them of the status. The plan shall offer each affected enrollee the option to return to that provider group or general acute care hospital. If an assigned enrollee does not exercise this option, the plan shall reassign the enrollee to another provider group or general acute care hospital.

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

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

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

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

10123.12. (a) Every health insurer, including those insurers that contract for alternative rates of payment pursuant to Section 10133, and every self-insured employee welfare benefit plan that will affect the choice of physician, hospital, or other health care providers, shall include within its disclosure form and within its evidence or certificate of coverage a statement clearly describing how participation in the policy or plan may affect the choice of physician, hospital, or other health care providers, and describing the nature and extent of the financial liability that is, or that may be, incurred by the insured, enrollee, or covered dependents if care is furnished by a provider that does not have a contract with the insurer or plan to provide service at alternative rates of payment pursuant to Section 10133. The form shall clearly inform prospective insureds or plan enrollees that participation in the policy or plan will affect the person's choice in this regard by

placing the following statement in a conspicuous place on all material required to be given to prospective insureds or plan enrollees including promotional and descriptive material, disclosure forms, and certificates and evidences of coverage:

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

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

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

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

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

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

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

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

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

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

(b) (1) At least ~~45~~ *30* 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 pursuant to Section 10133, the health insurer shall submit a filing to the department that includes the written notice the insurer proposes to send to the insureds. The insurer shall not send this notice to the insureds until the department has reviewed and approved the filing. If the department does not respond to the insurer within seven days of the date of its receipt of the filing, the filing shall be deemed approved.

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

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

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

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

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

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

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

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

(B) Any insured who has health care services authorized, but not yet scheduled as of the date of termination, or scheduled for after the date of termination at the terminated general acute care hospital.

(3) Allow insureds to continue to access services that were authorized or scheduled at the terminated provider group or general acute care hospital prior to the date of either the notice required by subdivisions (c) and (d), or the termination, whichever is later, regardless of whether the insured has requested completion of covered services. Those services shall be provided from the date of the contract termination until completion of the authorized or scheduled services for at least 60 days from the date of either the notice or the termination, whichever is later. The amount of, and the requirement for payment of, copayments, deductibles, coinsurance, and other cost-sharing components by an insured during the period of completion of authorized or scheduled services with a terminated provider group or general acute care hospital pursuant to this paragraph shall be the same that would be paid by the insured when receiving care from a provider currently contracting with the insurer.

(4) Provide reimbursement for services provided under paragraph (3) ~~either~~ at a rate agreed upon by the insurer and the terminated provider group or general acute care ~~hospital or~~ *hospital. If there is not an agreement, reimbursement shall be at* the rate for those services as provided in the terminating contract. In no event shall the provider bill the patient for the cost of services beyond the copayment, deductible, or other cost-sharing components of what the insured would have been responsible for if the provider group or general acute care hospital was currently contracted with the insurer.

(5) Obtain information from the terminated provider group or general acute care hospital regarding insureds who have health care services scheduled for after the date of termination with the terminated provider group or general acute care hospital, including the names of those insureds and the dates on which their services were ~~scheduled.~~ *scheduled by using the process agreed to in the terminating contract.* Unless otherwise prohibited by law, a terminated provider group or general acute care hospital ~~shall comply with a health insurer's request for that information.~~ *and the health insurer shall comply with the process in the terminating contract.*

(d) Even if a filing is not required to be submitted by subdivision (b), a health insurer shall send insured notices as required by subdivision (c). A health insurer may only send insured notices that have been filed and approved by the department pursuant to this section. *The department may develop a standard format for notices to be sent as required by this section.*

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

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

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

"If you have been receiving care from a health care provider, you may have a right to keep your provider for a designated time period. Please contact your insurer's customer service department, and if you have further questions, you are encouraged to contact the Department of Insurance, which protects insurance consumers, by telephone at its toll-free number, 800-927-HELP (4357), or at

a TDD number for the hearing impaired at 800-482-4833, or online at www.insurance.ca.gov."

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

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

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

10601. As used in this chapter:

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

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

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

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

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

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

(g) "Insurer" means every insurer transacting disability insurance and every self-insured employee welfare plan specified in subdivision (f).

(h) "Disclosure form" means the standard supplemental disclosure form required pursuant to Section 10603.

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

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

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

(a) The applicable category or categories of coverage provided by the policy, from among the following:

(1) Basic hospital expense coverage.

(2) Basic medical-surgical expense coverage.

(3) Hospital confinement indemnity coverage.

(4) Major medical expense coverage.

(5) Disability income protection coverage.

(6) Accident only coverage.

(7) Specified disease or specified accident coverage.

(8) Other categories as the commissioner may prescribe.

(b) The principal benefits and coverage of the disability insurance policy, including coverage for acute care and subacute care if the policy is a health insurance policy, as defined in Section 106.

(c) The exceptions, reductions, and limitations that apply to the policy.

(d) A summary, including a citation of the relevant contractual provisions, of the process used to authorize, modify, delay, or deny payments for services under the coverage provided by the policy including coverage for subacute care, transitional inpatient care, or care provided in skilled nursing facilities. This subdivision shall only apply to policies of health insurance as defined in Section 106.

(e) The full premium cost of the policy.

(f) Any copayment, coinsurance, or deductible requirements that may be incurred by the insured or his or her family in obtaining coverage under the policy.

(g) The terms under which the policy may be renewed by the insured, including any reservation by the insurer of any right to change premiums.

(h) A statement that the disclosure form is a summary only, and that the policy itself should be consulted to determine governing contractual provisions.

(i) For a health insurance policy, as defined in Section 106, all of the following:

(1) A notice on the first page of the disclosure form that conforms with all of the following conditions:

(A) (i) States that the form discloses the terms and conditions of coverage.

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

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

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

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

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

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

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

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

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

(6) A description of any limitations on the insured's choice of primary care physician, specialty care physician, or nonphysician health care practitioner, based on service area and limitations on the insured's choice of acute care hospital care, subacute or transitional inpatient care, or skilled nursing facility.

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

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

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

(10) A notice as required by Section 791.04.

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

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