

AMENDED IN SENATE APRIL 24, 2013

**SENATE BILL**

**No. 780**

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**Introduced by Senator Jackson**

February 22, 2013

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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.*

LEGISLATIVE COUNSEL'S DIGEST

SB 780, as amended, Jackson. ~~Disability insurance.~~ *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 distinguish between enrollees*

*of an assigned group provider and enrollees of an unassigned group provider for purposes of whether the 75-day 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 billing requirements 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.

~~The bill would require a health insurer to notify the department at least 30 days prior to terminating a contract with a provider group or general acute care hospital to provide services at alternative rates of payment if the contract termination would result in a material change to the provider network, and would require the insurer to send written notice, at least 15 days prior to the termination date of the contract, to all insureds who have obtained services from the provider group or general acute hospital within the last 6 months, as specified.~~

*This bill would require, among other things, a health insurer 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 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 billing requirements 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: ~~no~~-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) At least 75 days prior to the termination date of~~  
4     ~~its contract with a provider group or a general acute care hospital,~~  
5     ~~the health care service plan shall submit an enrollee block transfer~~  
6     ~~filing to the department that includes the written notice the plan~~  
7     ~~proposes to send to affected enrollees. The plan may not send this~~  
8     ~~notice to enrollees until the department has reviewed and approved~~  
9     ~~its content. If the department does not respond within seven days~~  
10    ~~of the date of its receipt of the filing, the notice shall be deemed~~  
11    ~~approved.~~

12    ~~(b) At least 60 days prior to the termination date of a contract~~  
13    ~~between a health care service plan and a provider group or a general~~  
14    ~~acute care hospital, the plan shall send the written notice described~~  
15    ~~in subdivision (a) by United States mail to enrollees who are~~  
16    ~~assigned to the terminated provider group or hospital. A plan that~~  
17    ~~is unable to comply with the timeframe because of exigent~~  
18    ~~circumstances shall apply to the department for a waiver. The plan~~  
19    ~~is excused from complying with this requirement only if its waiver~~  
20    ~~application is granted by the department or the department does~~  
21    ~~not respond within seven days of the date of its receipt of the~~  
22    ~~waiver application. If the terminated provider is a hospital and the~~  
23    ~~plan assigns enrollees to a provider group with exclusive admitting~~  
24    ~~privileges to the hospital, the plan shall send the written notice to~~  
25    ~~each enrollee who is a member of the provider group and who~~  
26    ~~resides within a 15-mile radius of the terminated hospital. If the~~  
27    ~~plan operates as a preferred provider organization or assigns~~  
28    ~~members to a provider group with admitting privileges to hospitals~~  
29    ~~in the same geographic area as the terminated hospital, the plan~~  
30    ~~shall send the written notice to all enrollees who reside within a~~  
31    ~~15-mile radius of the terminated hospital.~~

32    ~~(c) The health care service plan shall send enrollees of a~~  
33    ~~preferred provider organization the written notice required by~~  
34    ~~subdivision (b) only if the terminated provider is a general acute~~  
35    ~~care hospital.~~

36    1373.65. (a) *For the purposes of this section, the following*  
37    *terms have the following meanings:*

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

5 (2) “Assigned provider group” means a provider group to which  
6 a health plan directs its enrollees to receive specialty physician  
7 services or a provider group that includes primary care physicians  
8 to which a health plan assigns its members.

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

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

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

15 (b) (1) At least 75 days prior to the termination date of its  
16 contract with a provider group or a general acute care hospital,  
17 the health care service plan shall submit a filing to the department  
18 that includes the written notice the plan proposes to send to  
19 enrollees. The plan shall not send this notice to enrollees until the  
20 department has reviewed and approved the filing. If the department  
21 does not respond within seven days of the date of the filing, the  
22 filing shall be deemed approved.

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

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

34 (4) The director may adopt by regulation a different filing  
35 threshold from the threshold stated in paragraph (2), and in  
36 consultation with the Department of Insurance, may adopt by  
37 regulation a different filing threshold from the threshold stated in  
38 paragraph (3).

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

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

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

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

18 (A) Send the written notice described in subdivision (b), within  
19 one business day of the contract termination with an unassigned  
20 provider group, to all of the following persons:

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

24 (ii) Any unassigned enrollee who has any health care services  
25 scheduled with the terminated unassigned provider group after  
26 the date of termination.

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

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

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

36 (iii) Any enrollee who has authorized health care services  
37 scheduled at a terminating unassigned general acute care hospital  
38 after the date of termination.

39 (C) Allow enrollees to continue to access services that were  
40 authorized or scheduled at the terminated unassigned provider

group or unassigned general acute care hospital prior to the date of termination. Those services shall be provided until completion of the authorized or scheduled services for at least 60 days from the date of the notice unless a longer period of time is required pursuant to Section 1373.96. 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 unassigned provider group or unassigned 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 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.

(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.

~~(d)~~

(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 ~~notice~~ notices required by ~~subdivision (b)~~ subdivisions (c) and (d).

~~(e)~~

(f) If, after sending the ~~notice~~ notices required by ~~subdivision (b)~~ subdivisions (c) and (d), a health care service plan reaches an agreement with ~~a~~ 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

1 shall offer each affected enrollee the option to return to that  
2 provider. If an ~~affected~~ *assigned* enrollee does not exercise this  
3 option, the plan shall reassign the enrollee to another provider  
4 *group or general acute care hospital.*

5 ~~(f)~~

6 (g) A health care service plan and a provider shall include in  
7 all written, printed, or electronic communications sent to an  
8 enrollee that concern the contract termination or block transfer,  
9 the following statement in not less than 8-point type: ~~“If~~

10  
11 “If you have been receiving care from a health care provider,  
12 you may have a right to keep your provider for a designated time  
13 period. Please contact your HMO’s customer service department,  
14 and if you have further questions, you are encouraged to contact  
15 the Department of Managed Health Care, which protects HMO  
16 consumers, by telephone at its toll-free number, 1-888-HMO-2219,  
17 or at a TDD number for the hearing impaired at 1-877-688-9891,  
18 or online at [www.hmohelp.ca.gov](http://www.hmohelp.ca.gov).”

19  
20 ~~(g) For purposes of this section, “provider group” means a~~  
21 ~~medical group, independent practice association, or any other~~  
22 ~~similar organization.~~

23 SECTION 1.

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

26 10123.12. (a) Every health insurer, including those insurers  
27 that contract for alternative rates of payment pursuant to Section  
28 10133, and every self-insured employee welfare benefit plan that  
29 will affect the choice of physician, hospital, or other health care  
30 providers, shall include within its disclosure form and within its  
31 evidence or certificate of coverage a statement clearly describing  
32 how participation in the policy or plan may affect the choice of  
33 physician, hospital, or other health care providers, and describing  
34 the nature and extent of the financial liability that is, or that may  
35 be, incurred by the insured, enrollee, or covered dependents if care  
36 is furnished by a provider that does not have a contract with the  
37 insurer or plan to provide service at alternative rates of payment  
38 pursuant to Section 10133. The form shall clearly inform  
39 prospective insureds or plan enrollees that participation in the  
40 policy or plan will affect the person’s choice in this regard by



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

5  
6 PLEASE READ THE FOLLOWING INFORMATION SO  
7 YOU WILL KNOW FROM WHOM OR WHAT GROUP OF  
8 PROVIDERS HEALTH CARE MAY BE OBTAINED  
9

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

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

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

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

35 (1) A general description of the bonus and any other incentive  
36 arrangements used in its compensation agreements. Nothing in  
37 this paragraph shall be construed to require disclosure of trade  
38 secrets or commercial or financial information that is privileged  
39 or confidential, such as payment rates, as determined by the  
40 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. 2.~~

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

~~10133.57. (a) At least 30 days prior to the termination date of a contract between a health insurer and a provider group or a general acute care hospital to provide services at alternative rates of payment pursuant to Section 10133, the insurer shall submit a written notice notifying the department of the termination if the termination of the contract would result in a material change to the insurer's provider network, as defined by the department by regulation. The insurer shall include with that notice the written notice the insurer proposes to send to affected insureds pursuant to subdivision (b).~~

~~(b) At least 15 days prior to the termination date of a contract between a health insurer and a provider group or a general acute care hospital to provide services at alternative rates of payment pursuant to Section 10133, the insurer shall send the written notice described in subdivision (a) by United States mail to all insureds who have obtained services from the provider group or general acute care hospital within the preceding six months.~~

*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 75 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 insured within seven days of the date of the filing, the filing shall be deemed approved.*

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

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

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

12 (1) Send the written notice described in subdivision (b), within  
13 one business day of the contract termination with a provider group,  
14 to all of the following persons:

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

18 (B) Any insured who has any health care services scheduled  
19 with the terminated provider group after the date of termination.

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

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

26 (B) Any insured who has authorized health care services  
27 scheduled at a terminating general acute care hospital after the  
28 date of termination.

29 (3) Allow insureds to continue to access services that were  
30 authorized or scheduled at the terminated provider group or  
31 general acute care hospital prior to the date of termination. Those  
32 services shall be provided until completion of the authorized or  
33 scheduled services for at least 60 days from the date of the notice  
34 unless a longer period of time is required pursuant to Section  
35 10133.56. The amount of, and the requirement for payment of,  
36 copayments, deductibles, coinsurance, and other cost-sharing  
37 components by an insured during the period of completion of  
38 authorized or scheduled services with a terminated provider group  
39 or general acute care hospital pursuant to this paragraph shall

1 *be the same that would be paid by the insured when receiving care*  
2 *from a provider currently contracting with the insurer.*

3 *(4) Provide reimbursement for services provided under*  
4 *paragraph (3) either at a rate agreed upon by the insurer and the*  
5 *terminated provider group or general acute care hospital or the*  
6 *rate for those services as provided in the terminating contract. In*  
7 *no event shall the provider bill the patient for the cost of services*  
8 *beyond the copayment, deductible, or other cost-sharing*  
9 *components of what the insured would have been responsible for*  
10 *if the provider group or general acute care hospital was currently*  
11 *contracted with the insurer.*

12 *(d) Even if a filing is not required to be submitted by subdivision*  
13 *(b), a health insurer shall send insured notices as required by*  
14 *subdivision (c). A health insurer may only send insured notices*  
15 *that have been filed and approved by the department pursuant to*  
16 *this section.*

17 ~~(e)~~

18 *(e) If an individual provider terminates his or her contract or*  
19 *employment with a provider group that contracts with a health*  
20 *insurer—and that termination is subject to the requirements of*  
21 *subdivision (b), the insurer may require that the provider group*  
22 *send the notice required by subdivision (b) notices required by*  
23 *subdivisions (c) and (d).*

24 ~~(f)~~

25 *(f) If, after sending the notice required by subdivision (b) notices*  
26 *required by subdivisions (c) and (d), a health insurer reaches an*  
27 *agreement with a terminated provider group or general acute care*  
28 *hospital to renew or enter into a new contract or to not terminate*  
29 *its contract, the insurer shall send a subsequent written notice*  
30 *notifying the affected covered lives to all insureds that were sent*  
31 *the notices required by subdivisions (c) and (d) informing those*  
32 *insureds that the provider group or hospital remains in their*  
33 *provider network.*

34 ~~(e) A health insurer or a provider group shall include in the~~  
35 ~~written notice sent pursuant to subdivision (b) or (c) the following~~  
36 ~~information in not less than 12-point type:~~

37 ~~(1) The name of the terminated provider group or general acute~~  
38 ~~care hospital, or in the case of a notice sent pursuant to subdivision~~  
39 ~~(c), the name of the terminated individual provider.~~

40 ~~(2) The date of the pending contract termination.~~

1 ~~(3) A description explaining how to access a list of contracted~~  
2 ~~providers in the insured's provider network.~~

3 ~~(4) A statement that the insured may contact the insurer's~~  
4 ~~customer service department to request completion of care for an~~  
5 ~~ongoing course of treatment from a terminated provider and a~~  
6 ~~telephone number for further explanation.~~

7 ~~(5) A statement informing the insured that he or she may be~~  
8 ~~required to pay a larger portion of costs if the insured continues~~  
9 ~~to use the terminated provider.~~

10 ~~(6) The following statement:~~

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

15  
16 “If you have been receiving care from a health care provider,  
17 you may have a right to keep your provider for a designated time  
18 period. Please contact your insurer's customer service department,  
19 and if you have further questions, you are encouraged to contact  
20 the Department of Insurance, which protects insurance consumers,  
21 by telephone at its toll-free number, 800-927-HELP (4357), or at  
22 a TDD number for the hearing impaired at 800-482-4833, or online  
23 at [www.insurance.ca.gov](http://www.insurance.ca.gov).”

24  
25 ~~(f)~~

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

31 ~~SEC. 3.~~

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

34 10601. As used in this chapter:

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

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

39 (c) “Reduction” means any provision in a policy that reduces  
40 the amount of a policy benefit to some amount or period less than

1 would be otherwise payable for medically authorized expenses or  
2 services had the reduction not been used.

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

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

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

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

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

27 (i) “Small group health insurance policy” means a group health  
28 insurance policy issued to a small employer, as defined in Section  
29 10700, 10753, or 10755.

30 ~~SEC. 4.~~

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

33 10604. The disclosure form shall include at least the following  
34 information, in concise and specific terms, relative to the disability  
35 insurance policy, together with additional information as the  
36 commissioner may require in connection with the policy:

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

39 (1) Basic hospital expense coverage.

40 (2) Basic medical-surgical expense coverage.

1 (3) Hospital confinement indemnity coverage.

2 (4) Major medical expense coverage.

3 (5) Disability income protection coverage.

4 (6) Accident only coverage.

5 (7) Specified disease or specified accident coverage.

6 (8) Other categories as the commissioner may prescribe.

7 (b) The principal benefits and coverage of the disability  
8 insurance policy, including coverage for acute care and subacute  
9 care if the policy is a health insurance policy, as defined in Section  
10 106.

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

13 (d) A summary, including a citation of the relevant contractual  
14 provisions, of the process used to authorize, modify, delay, or deny  
15 payments for services under the coverage provided by the policy  
16 including coverage for subacute care, transitional inpatient care,  
17 or care provided in skilled nursing facilities. This subdivision shall  
18 only apply to policies of health insurance as defined in Section  
19 106.

20 (e) The full premium cost of the policy.

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

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

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

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

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

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

36 (ii) States, with respect to individual health insurance policies,  
37 small group health insurance policies, and any group health  
38 insurance policies, that the applicant has a right to view the  
39 disclosure form and policy prior to beginning coverage under the  
40 policy, and, if the policy does not accompany the disclosure form,

1 the notice shall specify where the policy can be obtained prior to  
2 beginning coverage.

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

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

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

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

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

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

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

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

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

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



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

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

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

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